PATIENT INFORMATION

Date______________

Name____

Mailing Address__________________________________

City__________________State_________Zip_________

Email____

Home#__________________Work#________________

Cell#____________________

Sex □ M □ F Age_______ Birthdate______________

□Single □Married □Widowed □Divorced

Patient's Social Security #_______________________

Occupation______________________________________

Employer____

Employer's Address_______________________________

Employer's Phone#_______________________________

If student, name of school_________________________

If student, what sports do you participate_____________

Referring physician______________________________

When is your next appointment

with the physician?_______________________________

Date of injury or onset of symptoms______________

IN CASE OF EMERGENCY, CONTACT

Name____

Home____________________Work________________

***Who is responsible for this account?*(GUARDIAN)**

Name____________________________________

Address__________________________________

City________________State______ Zip__________

Phone#___________________________________

Birthdate of parent/guardian________________________

SSN of parent/guardian___________________________

IF NAME ON INSURANCE CARD IS DIFFERENT FROM PATIENT WE NEED

Subscriber's Name___________________________

Address____

City________________State______ Zip__________

Birthdate of cardholder___________________________

SSN of cardholder_______________________________

Phone #____

SECONDARY INSURANCE

IF NAME ON INSURANCE CARD IS DIFFERENT FROM PATIENT ON SECONDARY INSURANCE WE NEED:

Subscriber's Name___________________________

Address____

City________________State______ Zip__________

Birthdate of cardholder___________________________

SSN of cardholder_______________________________

Was this a motor vehicle accident? □ Y □ N

If yes, state where accident occurred_____________

Insurance Company_____________________________

Adjuster's Name________________________________

Adjuster's Phone#_______________________________

Do you have an attorney? □ Y □ N

If yes, name of attorney_________________________

Attorney's phone#______________________________

Is this accident related to work? □ Y □ N

If yes, name of adjuster ________________________

MEDICAL HISTORY

Do you have any heart problems? □ Y □ N

If yes, explain

____

____

____

Do you have any other medical problems? □ Y □ N

If yes, explain

____

____

____

PAYMENT INFORMATION

As required by your insurance plan you are responsible for your major medical deductible, co-insurance percentage and/or co-pay amount.

Your major medical deductible is $_____________. Remaining amount of major medical deductible you are responsible for paying:_____________. The % you are responsible for paying is ______________ which would be approximately ______________ per visit. This will be adjusted on your bill as insurance pays. **Or** exact co-pay amount _________________ per visit.

Number of visits your insurance will allow _______

I hereby authorize Rehab Partners, P.C., to furnish information to insurance carriers concerning my illness and treatments and hereby assign Rehab Partners, P.C. all payments for physical therapy service rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay all costs of collections, including a reasonable attorney's fee, should this account be placed with an attorney for collection.

SIGNATURE:____________________________

Date:____________________

MEDICARE PATIENT INFORMATION

Medicare has a cap limit for physical therapy and we need to know in advance to verify that you do not exceed the cap limit.

Have you had physical therapy this year? This includes hospital, home health, rehab center, inpatient facility or other outpatient facility.

Yes Or No

If yes, where?________________________________

When?________________________________

How long did you have therapy?_______________________________

OFFICE USE ONLY

Date D/C from HH _______________________

Date Verified & contact person_____________

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