

WELCOME TO



REHAB AUTHORITY

Physical Therapy • Back & Neck Specialists

ACCOUNT NO. _____

PATIENT INFORMATION

Today's Date: _____ Physical Therapist Initials: _____

Patient Last Name: _____ First: _____ Social Security Number: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____ Marital Status: M S D W

Home Phone: () _____ - _____ Work Phone: () _____ - _____ Cell Phone: () _____ - _____

E-Mail Address: _____ Birth Date: _____ Sex: M F

Date of last Physician Visit: _____ Referring Physician: _____ PCP: _____ H/C UPIN: _____

Was this an Auto Accident? Y N Work Accident? Y N Date of Accident: _____ Attorney: _____

Tell us about your injury: _____

Diagnosis: _____ Code: _____

Nearest Relative Not Living With You: _____ Address: _____ Phone: _____

Whom may we contact in an Emergency: _____ Relation: _____ Phone: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? (Check all that apply)

Attorney: _____ Billboard/Sign/Location: _____ Doctor: _____ Insurance Provider: _____ Newspaper: _____

Phone Book: _____ Radio: _____ Return Patient: _____ Television: _____ Website: _____ Other: _____

Family/Friend/Self: _____

RESPONSIBLE PARTY

Responsible Party Name or Business Name: _____ Phone: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____ Relation to Patient: _____

Insured Party's Social Security Number: _____ - _____ - _____ Insured Party's Birth Date: _____ - _____ - _____

RESPONSIBLE PARTY EMPLOYER

Employer Name: _____ Phone: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

PATIENT OR SPOUSE EMPLOYER

Employer Name: _____ Phone: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: () _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Group and / or claim # _____ Member ID #: _____

Adjuster / Case Manager: _____ Relationship to Patient _____

Secondary Insurance: _____ Phone: () _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Group and / or claim #: _____ Member ID #: _____

Adjuster / Case Manager: _____ Relationship to Patient: _____

Thank you for choosing RehabAuthority. We look forward to helping you meet your rehabilitation needs. To help us serve you more efficiently, please read, sign, and date in the designated areas.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for RehabAuthority to furnish medical care and treatment to _____ as considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to RehabAuthority. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian _____ Date _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes and internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to RehabAuthority.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

ESTIMATED INSURANCE BENEFIT: _____

Estimated patient payment/co-payment: _____

Arrangement for payment of patient's share: _____

NOTE: Estimated coverage information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance.

**The above information has been read and explained to me.
I UNDERSTAND MY FULL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

Patient/ Guardian/ Responsible Party

Date

RehabAuthority Representative/ Witness

Date