PATIENT INFORMATION

Patient Name: ______________________________ SS#: ______________

Address: ______________________ City: ______________ Zip: __________

Phone: ____________ Patient Occupation: ______________________________

Date of Birth: __________ Driver's License #: ___________________________

Employer: ______________________________ Phone: ______________

Address: ____

Spouse: ________________________Spouse's employer: ________________

In case of emergency notify: _______________________ Phone: ______________

Referring Physician's name: _______________________ Phone: ______________

HEALTH INSURANCE INFORMATION

Primary insurance: ___________________________ Phone: ______________

Insured name (if other than the patient): ___________________________________

Relation to patient: ___________ Policy/Contract #: _________________________

Group #: __________ Effective Date: _________

Insured's employer: __________________________ Phone: ______________

Secondary insurance: _________________________ Phone: ______________

Insured name (if other than the patient): ___________________________________

Relation to patient: ___________ Policy/Contract #: _________________________

Group #: __________ Effective Date: _________

IF YOUR INJURY IS JOB RELATED COMPLETE THIS PORTION ALSO

Name of employer where injured: ______________________________

Employer's Address: ______________________________ Phone: ______________

Worker's Compensation Insurance: ______________________ Accident Date: __________

Claim #: ______________Contact person: ____________ Phone: ______________

IF YOUR INJURY IS DUE TO AN AUTO ACCIDENT COMPLETE THIS PORTION ALSO

Auto insurance company: ______________________________ Phone: ______________

Contact person: ______________________ Claim #: ______________________

Accident date: __________ Type of accident: ______________________________

Did you receive any physical therapy services for this condition in the last twelve months? **Yes or No**

If **yes**, where and when? ______________________________

How did you learn about our facility? ______________________________

Authorization to bill, I hereby authorize Family Rehab Care to bill my insurance company and receive the payment directly from them. I further authorize Family Rehab Care to release medical records to insurance companies in support of the billing and to the physician and other medical professionals involved in my treatment.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Family Rehab Care Inc. employee signature Date

WORKER'S COMPENSATION, AUTO & OTHER LIABILITY INSURANCE CLAIMS

If you expect that the charges for these services will be paid for by an insurance company because of the worker's compensation claim, auto accident or some other liability claim and you would like us to pursue the claim with the insurance company and possibly wait for payment until the case is settled, we need you to sign the following authorization.

AUTHORIZATION

Family Rehab Care Inc. assumes your right or the right of your beneficiaries, to recover money from another person, insurance company or organization. You grant us your right to recover services tendered to you, together with interest and cost, from the person, insurance company or organization. Your grant us a lien on all money that you or your beneficiaries recover through settlement, verdict or judgment. You agree to inform us when you hire an attorney to represent you and to inform your attorney of our right under this certificate. You are required to do whatever is necessary to help us enforce our right of recovery, including but not limited to, executing delivering instruments and paper necessary to secure those rights.

Patient Signature ______________________ Date __________

Family Rehab Care Inc. employee signature ______________________ Date __________

Attorney ______________________ Phone __________

Address __________ City __________ State ____ Zip ______