Pro-Rehab Services

Physical Therapy and Rehabilitation Center

PATIENT INFORMATION

(Please complete both sides of form)

Date _____ Clinic _____ MRN# _____

Name _____
First Last Middle

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birth Date _____ Social Security # _____ E-Mail _____

Marital Status M ☐ S ☐ W ☐ Sex M ☐ F ☐

How did you hear about us? Referred by Former Patient ☐ Physician ☐ Family ☐ Other ☐ Specify _____

Have you been treated at any of our facilities before? _____ If so, when ? _____

REFFERING INFORMATION

Referring Physician _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

Primary Care Physician _____ Address _____

City _____ State _____ Zip _____

Phone Number _____ Would you like us to send copies of correspondence to your Primary

Care Physician? Yes ☐ No ☐

Is this an Auto Accident? Yes ☐ No ☐ Is this an approved Workers Comp Injury? Yes ☐ No ☐

Is this a Personal Injury or Third Party Liability Case? Yes ☐ No ☐

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INSURANCE INFORMATION

Primary Insurance Company _____

Name of Policy Holder _____ Relationship to Patient _____

Ins. Co. Phone No _____ Policy Holder Date of Birth _____

Policy ID # _____ Group # _____

Secondary Insurance Company _____

Name of Policy Holder _____ Relationship to Patient _____

Ins. Co. Phone No. _____ Policy Holder Date of Birth _____

Policy ID # _____ Group # _____

WORKMAN'S COMPENSATION

Employer's Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Phone _____ Claim Adjuster Name _____ Claim # _____

Claim Adjuster Phone _____

Claim Insurance Company Name _____ Phone No _____

Rehab Nurse Name _____ Phone No _____

AUTO ACCIDENT / PERSONAL INJURY OR THIRD PARTY LIABILITY

Insurance Company name _____ Phone No _____

Contact Name _____ Claim No _____

Attorney Name (if applicable) _____ Phone No _____

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TREATMENT AUTHORIZATION

Your signature is required below to authorize treatment. By signing, you also authorize the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies.

Patient Signature Date

In case of Minors, Parent or Guardian Signature Print Full Name Date

HIPAA AUTHORIZATION

In compliance with HIPAA regulations, I authorize the following individuals to receive information regarding the billing of my account.

Name/Relationship Name/Relationship Name/Relationship

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of Pro-Rehab Services' Notice of Privacy Practices. Pro-Rehab Services will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand Pro-Rehab Services has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.
I give my consent for Pro-Rehab Services to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Pro-Rehab Services.

Signed: _____ Date: _____