



**Pro-Rehab Services**  
Physical Therapy and Rehabilitation Center

**INSURANCE INFORMATION**

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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**

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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**

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Insurance Company name \_\_\_\_\_ Phone No \_\_\_\_\_

Contact Name \_\_\_\_\_ Claim No \_\_\_\_\_

Attorney Name (if applicable) \_\_\_\_\_ Phone No \_\_\_\_\_

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**TREATMENT AUTHORIZATION**

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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.

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Patient Signature

Date

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In case of Minors, Parent or Guardian Signature

Print Full Name

Date

**HIPAA AUTHORIZATION**

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

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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: \_\_\_\_\_

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