REHAB PARTNERS

PATIENT INFORMATION

Date _____

Name _____

Street Address _____

City_____ State _____ Zip _____

Email Address _____

Sex ☐ M ☐ F Age _____Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Social Security # _____

Occupation_____

Employer _____

Employer's Address_____

Employer's Phone _____

Spouse's Name _____

Spouse's Birthdate_____SSN_____

Spouse's Employer _____

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

Home _____ Work _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Home _____ Work _____

INSURANCE

Who is responsible for this account?

_____

Relationship to patient ☐ Self ☐ Spouse
☐ Parent ☐ Other

Subscriber's Name _____

Subscribers Address _____

City_____ State _____ Zip_____

Birthdate of cardholder _____

SS# of Cardholder _____

Is patient covered by additional insurance? ☐ Y ☐ N

Subscriber's Name _____

Subscriber's Address_____

City_____ State _____ Zip_____

Birthdate _____ SS# _____

Relationship to patient ☐ Self ☐ Spouse ☐ Child

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 your adjuster _____

Adjuster's Phone _____

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_____

How did you hear about Rehab Partners?

☐ Physician ☐ Friend/Relative ☐ TV ☐ Radio ☐ Newspaper ☐ Other

I hereby authorize Rehab Partners, P.C. to furnish information to insurance carriers concerning my illness and treatments and hereby assign to Rehab Partners, P.C. all payments for physical therapy services 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 collection, including a reasonable attorney's fee, should this account be placed with an attorney for collection.

*NOTE: When making appointments, remember this time was set aside for you. If you can not keep your appointment, please call and cancel.

DATE: _____SIGNATURE:_____

*REMEMBER, insurance is there to help reduce the cost of treatments - not eliminate it.

WORKER'S COMPENSATION PATIENTS ONLY

Physical therapy is being provided to me as prescribed treatment for a work-related injury. I hereby authorize Rehab Partners, P.C. to furnish information to my employer and/or worker's compensation carriers concerning my injury and treatments.

I understand Rehab Partner, P.C. is responsible for notifying my adjuster, case manager, and doctor if I fail to meet my prescribed number of treatments each week. I understand my attendance is mandatory unless excused by my case manager, doctor, or therapist. It is my responsibility to be on time and give my best effort.

DATE:_____SIGNATURE:_____