

**Advanced Rehab, PC**

**Patient Registration Forms**

<b>Patient Name</b>				<b>Date</b>	
Mailing Address			Home Phone		
City		State		Birth Date	
Social Security Number			Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		
Employer			Address		
Work Phone			Referred By		
Most Recent Doctor Visit				Next Doctor Visit	

**Insurance Coverage** (Please Check Appropriate Carrier and Supply Policy Number)

Blue Cross/Blue Shield #		Policy Holder's Name	
Medicare #		Medicaid #	
Workers Comp Case #		Date of Injury	
Referring Physician			
Other Insurance Name			
Insurance Address			
Policy Number		Policy Holders Name	

**Responsible Party** (If bringing a child under 18 years old)

Responsible Party Name (If no Parent)			
Mailing Address		Home Phone	
City		State	Zip
Birth Date		Employer	
Employer Address		Work Phone	
Social Security Number		Relationship to Patient	

**Accident/Injury Information**

Type of Injury (check one)    Worker's Compensation     Auto Accident

Employer at Time of Accident		Date of Injury	
Brief Description of Injury/Accident			
Attorney		Address	
Phone			
Name of the Nearest Relative NOT Living with You			
Address		Phone	

Release of Information- Payment Agreement  
Cancellations/NO-Shows- Assignment of Benefits

**Release of Information:** I Hereby authorize Advanced Rehab to release information to my referring provider, billing agency, transcription service, my insurance company and:

1. \_\_\_\_\_ 2 \_\_\_\_\_  
3. \_\_\_\_\_ 4 \_\_\_\_\_

Information will not be released to any other party without my (the patient's) permission

**Payment Agreement:** I understand that it is my responsibility to pay for all charges, regardless of insurance or other third party coverage. I understand that I am expected to pay the balance due on my account each month. This applies even with services that are on going. A minimum monthly payment of \$25.00 or 10% of the balance, whichever is higher, may serve as a payment schedule until the balance is paid in full. In the event any action is necessary by either party to this agreement in order to enforce covenants, rights or obligations in this agreement, it is agreed that the prevailing party shall receive payment of all costs, including reasonable attorney's fees.

**Cancellations/No Shows:** If during the course of treatment, I cancel a **scheduled** appointment I will notify Advanced Rehab at least 24 hours before the appointment. If I fail to give 24 hours notice cancellation, I understand that I will be charged \$15.00 that is not billable to insurance companies. Not Showing up for an appointment without notification will be charged \$25.00 that is not billable to insurance companies.

**Assignment of Insurance:** I Authorize payment of medical benefits to Advance Rehab.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Witness** \_\_\_\_\_

**Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_ **Witness** \_\_\_\_\_

You will be asked to fill out a health history questionnaire when you arrive at the clinic. You may save time by listing the following below:

Please List your Medications: \_\_\_\_\_

\_\_\_\_\_

Supplements: \_\_\_\_\_

\_\_\_\_\_