



Patient Information Form for Insurance or Private Pay

Date: _____ Date/ Time of Eval _____ P.T.: _____
Date of Injury: _____ Type of Referral: WC Priv. Ins. (PPO) MC Lien Other: _____
Referring Doctor: _____ Diagnosis: _____
Team Name: _____ Coach's Name: _____
Coach's Phone #: _____ Coach's E-mail Address: _____

PATIENT'S NAME: _____

SSN#: _____ DOB: ____/____/____ SEX: _____

Address: _____ Phone (H): _____

City: _____ State: _____ ZIP: _____ Phone (W): _____

Employer: _____ Occupation: _____ Phone (Cell) _____

E-mail address: _____

Emergency Contact (not living with you): _____ Phone: _____

PRIVATE PAY:

Referral Source: _____

Rate for Evaluation: _____

Rate for Treatment: _____

Notes: _____

PRIVATE INSURANCE:

PPO or POS

Insurance Co.: _____ Group #: _____

Subscriber ID: _____ Payor #: _____

Billing Address: _____

Phone #: _____ FAX #: _____ Other #s: _____

Contact Person/Adjuster's Name: _____ Effective Date: _____

Is the Patient part of a Medical Group? _____

Rx Req.? Yes No Auth/ Pre-Cert Req.? Yes No # To Req. Auth: _____

In Network: Amt. of Ded. _____ Ded. Met? Y N Amount Met _____ Co-Pay _____

Visits/Yr: _____ Used: _____ Out of Pocket Max/Yr. _____ Lifetime Max: _____

Out-of-Network: Amt. of Ded. _____ Ded. Met? Y N Amount Met _____

Visits/Year: _____ Ins. % _____ Co-Ins. % _____ Out of Pocket Max/Yr. _____

Notes: _____

I hereby authorize payment directly to Rehab United of all benefits otherwise payable to me for services rendered by Rehab United but not to exceed the reasonable and customary charges for these services. I understand that I am responsible for charges not covered by my insurance or lien and for the accuracy of the information stated above. We reserve the right to charge for appointments cancelled without 24 hours advance notice as noted on "Patient Responsibilities" form.

Signed: _____ Date: _____