REHAB PARTNERS

PATIENT INFORMATION

Date _____

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Email _____

PHONE NUMBERS

Home _____ Work _____ Cell _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Home _____ Work _____

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 _____

MORE INFORMATION ON THE BACK

INSURANCE

Who is responsible for this account?

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Subscriber's Name _____

Subscriber's 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 of Gadsden?

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

I hereby authorize Rehab Partners of Gadsden to furnish information to insurance carriers concerning my illness and treatments and hereby assign to Rehab Partners of Gadsden 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 place with an attorney for collection.

*NOTE: When making appointments, remember this time was set aside for you. If you cannot 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 of Gadsden to furnish information to my employer and/or worker's compensation carriers concerning my injury and treatments.

I understand Rehab Partners of Gadsden 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:_____