



# Patient Information Form

Date: \_\_\_\_\_

## Patient Information

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Last Date Worked: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Spouse's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## Insurance Information

(Payments including insurance co-pays are due at time of service)

Primary Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

## Consent To Treat

I consent to any medical treatment rendered as a patient under the general or special instructions of Medical Rehabilitation Specialists.

### Co-Pays / Assignment of Insurance Benefits

Co-pays are due at the time of service. The receptionist will request a copy of your current insurance card at each visit. I authorize direct payment of medical benefits to Medical Rehabilitation Specialists (MRS) for services rendered. I understand that MRS will file a claim with my insurance company on my behalf, but that I will be held responsible for payments of my account regardless of my insurance coverage or my insurance authorization (unless my condition is covered through a valid workers' compensation claim).

I also authorize the release of any medical information regarding my physical condition, in the possession of MRS or any other medical provider, which may be requested in order to process claims for MRS and/or for my care.

### Missed Appointment Policy

Please be aware, we do charge a \$30 fee for missed appointments without 24 hour notice. You will not be rescheduled until this fee is paid. Worker's Compensation and IME fees are per the applicable guidelines.

### Discharge Policy

To be fair to all patients, it is our company policy that if a patient fails to show for 3 appointments the patient will be discharged from the practice.

\_\_\_\_\_

Date \_\_\_\_\_

(Signature of Patient / Parent or Guardian of Minor)