

PATIENT INFORMATION

PATIENT NAME _____ HOME PHONE _____
STREET/CITY/STATE/ZIP _____
SS# _____ BIRTHDATE _____ AGE _____
MARITAL STATUS S M D W SPOUSES NAME _____
SPOUSES ADDRESS _____
SPOUSE SS# _____ SPOUSES BIRTHDATE _____
DATE OF FIRST SYMPTOM _____ DATE OF NEXT DOCTOR APPT _____

IS THIS A WORK RELATED INJURY () YES () NO DATE OF INJURY _____
EMPLOYER NAME/ADDRESS _____
EMPLOYER PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT PAYMENTS

NAME _____ RELATIONSHIP TO PATIENT _____
STREET/CITY/STATE/ZIP _____
HOME PHONE _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU

NAME _____ HOME PHONE _____
STREET/CITY/STATE/ZIP _____

CONSENT FOR TREATMENT- MUST BE SIGNED BY PARENT/GUARDIAN IF UNDER AGE 18.
I AUTHORIZE SERVICES AND TREATMENT TO BE PROVIDED BY PROFESSIONAL
REHABILITATION SERVICES.LLC.

SIGNATURE

DATE

**WE MUST HAVE A COPY OF YOUR INSURANCE CARDS SO THAT WE MAY SUBMIT
YOUR CLAIMS.**

I HEREBY ASSIGN MEDICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH
I AM ENTITLED, INCLUDING PRIVATE INSURANCES AND OTHER HEALTH PLANS TO
PROFESSIONAL REHABILITATION SERVICES, LLC. I AUTHORIZE PAYMENT DIRECTLY TO
PROFESSIONAL REHABILITATION SERVICES, LLC. I AUTHORIZE RELEASE OF MY MEDICAL
RECORDS IN ORDER FOR PRS TO OBTAIN PAYMENT. WE DO NOT ACCEPT THIRD PARTY
CLAIMS.

I HEREBY ACKNOWLEDGE RECEIPT OF PROFESSIONAL REHABILITATIONS SERVICES, LLC
NOTICE OF PRIVACY PRACTICES.

SIGNATURE

DATE

WORKERS COMPENSATION

I HEREBY AUTHORIZE PROFESSIONAL REHABILITATION SERVICES, LLC TO RELEASE MY MEDICAL RECORDS WHETHER RELATED TO PRIOR OR SUBSEQUENT MEDICAL TREATMENT PROVIDED TO ME TO THE EMPLOYEES OR AGENTS OF MY EMPLOYER, MY INSURANCE COMPANY OR THE INSURANCE COMPANY OF MY EMPLOYER. IF YOUR WORK COMP CLAIM IS DENIED AT ANY TIME , YOU MAY BE HELD RESPONSIBLE FOR PAYMENT. IN THE EVENT YOUR CLAIM IS DENIED YOU MUST FURNISH US WITH A GROUP HEALTH INSURANCE IF YOU WOULD LIKE US TO FILE THE CLAIM AS A COURTESY. HOWEVER, DUE TO TIMELY FILING LIMITATIONS IMPOSED BY MANY INSURANCE CARRIERS, YOUR PRIVATE INSURANCE COMPANY MAY DENY THE CLAIM. ANY RESIDUAL BALANCES WILL BE YOUR RESPONSIBILITY.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION ANYTIME IN WRITING TO PROFESSIONAL REHABILITATION SERVICES, LLC. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS AN ORIGINAL.

SIGNATURE

DATE

UNITED HEALTHCARE PATIENTS:

PROFESSIONAL REHABILITATION SERVICES IS NOT AN OUTPATIENT FACILITY. OFFICE VISIT CO-PAYS WILL APPLY.

MEDICARE PATIENTS:

MEDICARE HAS A \$1780.00 CAP FOR PHYSICAL THERAPY AND SPEECH PATHOLOGY FOR 2007. YOU MUST NOTIFY PRS OF ALL PROVIDERS WHO TREATED YOU DURING THE CALENDAR YEAR. YOU MAY BE FINANCIALLY LIABLE FOR ALL CHARGES INCURRED AFTER YOUR CAP OF \$1780.00 HAS BEEN REACHED. THERE ARE CERTAIN EXEMPTIONS WHICH ALLOW FOR TREATMENT OVER THE CAP. THE FRONT OFFICE WILL DISCUSS THESE EXEMPTIONS IF YOU QUALIFY.

MEDICARE PAYS 80% OF THEIR ALLOWABLE FEE SCHEDULE. IF YOU DO NOT HAVE A SUPPLEMENTAL (2ND) INSURANCE YOU WILL BE RESPONSIBLE FOR THE OTHER 20%.

MEDICARE REQUIRES YOU TO SEE YOUR DOCTOR FOR NEW PT ORDERS 60 DAYS AFTER THE FIRST ORDER, 30 DAYS AFTER EACH ADDITIONAL ORDER.

BENEFITS INSURANCE

OUR OFFICE HAS CONTACTED YOUR INSURANCE COMPANY REGARDING YOUR THERAPY BENEFITS. YOUR INSURANCE COMPANY HAS ADVISED US THAT YOU HAVE A \$_____ DEDUCTIBLE PER YEAR, WITH COVERAGE OF _____% AND/OR A CO-PAY OF \$_____ PER OFFICE VISIT. YOU WILL RECEIVE A STATEMENT FOR OUTSTANDING DEDUCTIBLES, CO-INSURANCES OR ANY NON-COVERED SERVICES. THE INFORMATION PROVIDED BY YOUR INSURANCE COMPANY DOES NOT GUARANTEE PAYMENT AND/OR BENEFITS. YOUR INSURANCE PAYS FOR ____ VISITS PER CALENDAR YR.

I UNDERSTAND AND AGREE THAT IF I FAIL TO MAKE ANY OF THE PAYMENTS FOR WHICH I AM RESPONSIBLE, ALL COST OF COLLECTING MONIES OWED INCLUDING 1.50% INTEREST MONTHLY ON ANY BALANCES OVER 90 DAYS, COURT COSTS, COLLECTION AGENCY FEES (20%) AND ATTORNEY FEES SHALL BE MY RESPONSIBILITY.

SIGNATURE

DATE