Professional Rehab Associates
Registration Forms

Patient Information Todays Date: _____ SSN_____

Name: _____ _____ Sex : M F
Last First MI Circle

Age: _____ Birth Date: _____ Marital Status: _____ Race: _____

Street Address _____City _____ State _____Zip_____

Mailing Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Employer Phone _____

Responsible Party

Name: _____ Sex: M F SSN _____
Last First MI Circle

Address: _____ City: _____ State ____ Zip _____

Employer: _____
Company Name Address City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Insurance Information

Insurance Company: _____ Policy Number: _____

Insured Name: _____
Last First

Relationship to Patient: _____ Insured's Date of Birth_____

Emergency Contact Name: _____ **Phone Number:** _____
Relationship to Patient : _____

Referrals to Medical Providers

During treatment of your injury, you may need to be referred elsewhere for further evaluation and/or treatment of your condition. Your treating therapist may refer you to another healthcare facility, hospital, medical product supplier, or healthcare provider. Any referral to a specific provider for any type of service should not be considered as an exclusive, recommended source of treatment by Professional Rehab Associates, Inc. You have the absolute right to choose your medical care providers and are encouraged to do so. The mission of Professional Rehab Associates, Inc. is to provider quality care in a secure and friendly environment while minimizing your time in treatment. I have read the above statement and understand that I have the exclusive right to choose the provider of my choice for my rehab need.

_____
Signature Date

HIPPA INFORMATION

I authorize the staff of Professional Rehab Associates, Inc. to discuss my medical or payment information with the following person. This authorization shall remain in effect until such time as it is withdrawn by me in writing.

Name: _____ Relationship _____

Name: _____ Relationship _____

FINANCIAL INFORMATION

If we are a provider for your insurance, we will submit your claim to your insurance company. You are responsible for your co-pay and/or portion that your insurance company requires on the date services are rendered. The amount collected at time of service is an estimate only. You may receive a bill for the remainder amount that the insurance does not pay. Payment not received by the insurance company within 60 days of filing become patient responsibility. Non-covered and disallowed charges are your responsibility unless our Agreement with your insurance company providers otherwise. IT IS YOUR RESPONSIBILTY TO INFORM US OF ANY CHANGES REGARDING YOUR INSURANCE.

Liability insurance claims and athletic insurance claims must be paid on date of service and reimbursed to you by the responsible company. It is your responsibility to file these claims.

Worker's Compensation Claims and any other procedures paid by your company must be approved in advance of the visit by the company who is responsible for the claim. If we are unable to obtain an approval in advance of the visit you will be responsible for all charges at time of service.

If we are not a provider for your insurance company we will be glad to file your insurance as a courtesy to you, but all charges are due at the time of service. If you have no insurance all charges are due at time of service. There will be a $40.00 service charge on all returned checks.

The parent of a minor child bringing the child to the clinic for treatment, or authorizing treatment of the child, is the responsible party for any financial obligations incurred as a result of the treatment. We will not bill another party for the child's treatment.

We reserve the right to refuse service due to improper conduct or harassment.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICIES. I UNDERSTAND THAT THIS DOES NOT GUARANTEE INSURANCE PAYMENT OR THE DENIAL OF INSURANCE PAYMENT. IF IS UNDERSTOOD THAT ONLY MY INSURNACE COMPANY OR COMPANIES CAN MAKE THAT DETERMINATION. I FURTHER UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY COURT COSTS,ATTORNEY FEES OR INTEREST THAT MY BE INCURRED IF I SHOULD FAIL TO PAY ALL BALANCES DUE UPON RECEIPT OF BILLED CHARGES.

I authorize that payment be made to Professional Rehab Associates, Inc and authorize release of any information necessary to process the claim for services rendered to me. I also authorize the release of information to Medicare, or third party payers, medical and non-medical information, including employment status, and whether I have group health insurance, liability, no-fault, workers compensation or other insurance, which is responsible to pay for the services for which a Medicare or other claim is made.

NOTE If you are being seen for a work related injury or procedure paid for by your company, a copy of these office notes will be sent to your company for payment.

_____ _____

Signature of Patient or Responsible Party Date

I, or the patient listed for whom I am legally responsible, am suffering from a condition requiring treatment. I consent to such procedures, treatment, considered necessary by the therapist. I am aware that the practice of Physical and Occupational Therapy is not an exact science and I acknowledge that no guarantees have been made to me as a result of said treatment that I authorize.

_____ _____

Signature of Patient or Responsible Party Date

I, the undersigned, do hereby acknowledge receipt of Professional Rehab Associates, Inc. Privacy Notice.

_____ _____

Signature of Patient or Responsible Party Date