Neuro Rehab Associates, Inc.

Patient Information

PATIENT (LEGAL) NAME:_____ AGE: _____ BIRTHDATE: _____SEX: M / F

PHONE: _____ CELL: _____ May we leave a message on your voice mail? Y N

EMAIL ADDRESS _____ Would you like us to text or email (Circle one) your appointment reminders? Yes No

PHYSICAL ADDRESS: _____
City State Zip

MAILING ADDRESS: _____

EMPLOYER: _____ PHONE: _____

SPOUSE NAME: _____ SPOUSE DOB: _____ PHONE: _____

May we discuss information regarding your bill, treatment, schedule with your spouse? Circle all that apply. Yes No

PHYSICIAN ORDERING THERAPY: _____

Injury or illness (Circle one)- Date:_____ If injury, was this related to an Auto Accident? Yes No
State of accident: _____ How did you hear about us? _____

INSURANCE INFORMATION

PRIMARY INS: POLICY HOLDER NAME: _____ DOB: _____
RELATION: _____

INSURANCE COMPANY: _____ ID/CLAIM #:_____ GROUP#: _____

SECONDARY INS: POLICY HOLDER NAME: _____ DOB: _____
RELATION: _____

INSURANCE COMPANY: _____ ID/CLAIM #:_____ GROUP#: _____

COMPLETE THIS SECTION IF PATIENT IS UNDER 18 OR IS A COVERED DEPENDENT

(Please note: if you are over 18, but covered by your parent's insurance plan, we can bill your parent's insurance as a courtesy, please understand you are ultimately responsible for any unpaid balances on your account.

MOTHER'S INFORMATION: NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____ EMPLOYER: _____ WORK PHONE: _____

FATHER'S INFORMATION: NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____ EMPLOYER: _____ WORK PHONE: _____

PLEASE READ- IMPORTANT INFORMATION

1) I consent to examination, treatment and procedures that may be performed during office visits considered necessary by the therapist.
2) I understand is it my responsibility to determine if my insurance will cover therapy I receive at Neuro Rehab Associates.
3) I understand that I am financially responsible for all charges whether or not paid by my insurance.
4) I authorize the release of medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
5) I authorize and request that any insurance benefits be paid directly to **Neuro Rehab Associates, Inc.**
6) I agree to make monthly payments on unpaid balances exceeding sixty (60) days even when insurance claims are pending.
7) I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs, will be added to the balance of my account.
8) If Neuro Rehab Associates bills my insurance company directly, I will pay my co-payments that coincide with my insurance policy. The co-payment is payable on or per visit or on a weekly basis or when I receive an invoice.
9) Per HIPAA regulations, I acknowledge that this office has a posted notice available in the patient reception area. A copy of available by request and is on the Neuro Rehab Associates website- www.boztherapy.com. We will not disclose your health information without your authorization, except as described in this notice.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARDIAN IF PATIENT IS A MINOR) DATE