



Patient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

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

Home Tele # \_\_\_\_\_ Cell# \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

Sex: M F Marital Status: Married Single Widowed Divorced

Email Address \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Tele# \_\_\_\_\_

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Payment from: (circle) Self pay TRICARE Auto Insurance Insurance Medicare

Was this a work related injury? Yes or No; Was this an auto accident? Yes or No

Date of injury: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SSN \_\_\_\_\_

Relationship: (circle) Self Spouse Child Parent Other: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address \_\_\_\_\_ Tele# \_\_\_\_\_

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Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Tele#: \_\_\_\_\_

Physician: \_\_\_\_\_ Tele# \_\_\_\_\_

Diagnosis \_\_\_\_\_

Last Seen by MD: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_ Next Appt. to see MD \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize R&R Rehabilitation to release any medical information necessary to process insurance claims and hereby certify that the above information is correct.

**AUTHORIZATION TO PAY BENEFITS:** I hereby authorize payment of benefits directly to R&R Rehabilitation medical services rendered. I FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE AND HEREBY AGREE TO PAY SUCH BALANCE.

**ACKNOWLEDGEMENT:** I hereby acknowledge that I have received, read and agree to the PATIENT PAYMENT.

**TREATMENT CONSENT:** I hereby request physical, occupational and/or speech therapy treatment by the licensed clinicians at R&R Rehabilitation. I authorize the clinicians to perform any and all forms of treatment, medication, and therapy that may be indicated.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_