



Patient's Name: _____

SSN: _____

Address: _____ City/State: _____

Zip: _____

Home Tele # _____ Cell# _____ D.O.B. _____

Age: _____ Sex: M F Marital Status: Married

Single Widowed Divorced

Occupation: _____

Employer: _____

Employer's Address: _____ Tele

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# _____

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: _____