NEURO REHAB ASSOCIATES, INC

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COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

PATIENT IDENTIFICATION:

NAME: (Please Print) _____

DATE OF BIRTH:_____

Please list family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kind of information we can share with each individual.

NAME	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION (check all that apply)			
		ALL	SCHED/ APPTS	MEDICAL	BILLING/ INSURANCE
_____	_____	___	____	____	____
Address: _____		Phone number: _____			
_____	_____	___	____	____	____
Address: _____		Phone number: _____			
_____	_____	___	____	____	____
Address: _____		Phone number: _____			
_____	_____	___	____	____	____
Address: _____		Phone number: _____			
_____	_____	___	____	____	____
Address: _____		Phone number: _____			

Specific Instructions or limitations:

_____

_____

_____

We will continue to use the information on this form when communicating with family members or others involved in your care unless you request changes.

Signature of Patient/
Legal Representative: _____

Relationship to Patient: _____ Date: _____