ICD 10: ST Med. ________________ Tx. ______________
OT Med. ________________ Tx. ______________

Neuro Rehab Associates, Inc.

Patient Information- Auto Insurance

PATIENT (LEGAL) NAME:_______________________________________ AGE: ________ BIRTHDATE: _______________SEX: M / F

SSN: _________________________ PHONE: _________________________________ CELL: ________________________________

EMAIL ADDRESS __________________________ Would you like us to text or email (Circle one) you 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: ____

How did you hear about us? ____

AUTO INSURANCE INFORMATION

POLICYHOLDER NAME: ___________________________________ INSURANCE COMPANY ___________________________________

POLICY NUMBER: ______________________________ADDRESS: ____

PHONE: __________________________

CLAIMS ADJUSTER: ____ PHONE: __________________________

DATE OF ACCIDENT: ____________ CLAIM NUMBER: ___________________________ STATE OF ACCIDENT: __________________

ATTORNEY: ____ PHONE: __________________________

SHOULD THE AUTO INSURANCE DENY LIABILITY FOR THE CHARGES, WE CAN BILL YOUR PRIVATE INSURANCE

*(**Please note**: Please provide your private insurance information and/or a copy of your Insurance Card)*

POLICY HOLDER NAME: _____________________________________ DOB: ______________ RELATION: ____________________

INSURANCE COMPANY: _____________________________________ ID/CLAIM #:__________________ GROUP#: ____________

IF UNDER 18 OR A COVERED DEPENDENT

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 authorize **Neuro Rehab Associates, Inc.** to request information from my attending physician, vocational rehabilitation, employer, and/or insurer if needed.
3) I authorize the release of medical information to my insurance company and to such other persons/organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA).
4) I understand that should the Auto Insurance deny liability for these charges, I am financially responsible.
5) I authorize and request that any insurance benefits be paid directly to **Neuro Rehab Associates, Inc.**
6) 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.
7) 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