ICD-10: ST Med. _____ Tx. _____
OT Med. _____ Tx. _____

Neuro Rehab Associates, Inc.

Patient Information

PATIENT (LEGAL) NAME:_____ AGE: _____ BIRTHDATE: _____

SEX: M / F SSN: _____ PHONE: _____ CELL: _____

EMAIL ADDRESS (for appointment reminders)_____

PHYSICAL ADDRESS: _____
City State Zip

MAILING ADDRESS: _____

EMPLOYER: _____ PHONE: _____

SPOUSE NAME: _____ SPOUSE DOB: _____ PHONE: _____

SPOUSE EMPLOYER: _____ SPOUSE WORK PHONE: _____

PHYSICIAN ORDERING THERAPY: _____

Injury or Illness (circle one)- Date: _____ If Injury, was this related to an Auto Accident? Yes No
How did you hear about us? _____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 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 for you 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: _____

INSURANCE INFORMATION

PRIMARY:
POLICYHOLDER NAME: _____ DOB: _____ RELATION: _____

INSURANCE COMPANY: _____ ID: _____ GROUP#: _____

SECONDARY:
POLICYHOLDER NAME: _____ DOB: _____ RELATION: _____

INSURANCE COMPANY: _____ ID: _____ GROUP#: _____

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 the release of any 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.
3) I understand it is my responsibility to determine if my insurance will cover therapy I receive at Neuro Rehab Associates.
4) I understand that I am financially responsible for all charges whether or not paid by my insurance.
5) 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.
6) I agree to make monthly payments on unpaid balances exceeding sixty (60) days even when insurance claims are pending. These payments will be established in accordance with Neuro Rehab Associates policy.
7) A one percent (1%) finance charge may be assigned against the unpaid balance of any and all accounts that I am responsible for in accordance with Neuro Rehab Associates policy.
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 a per visit or 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