

Rehabilitation Associates of the Main Line, P.C.

Patient Information Form

PLEASE COMPLETE ALL INFORMATION:

Last Name: _____ First Name: _____ MI _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ E-Mail Address: _____

Sex: M F Marital Status: S M W D Other Age _____ Date of Birth: _____

Employer: _____ Employer Phone #: _____

Spouse's Name: _____ Spouse's Work Phone: _____

Emergency Contact (other than spouse): _____ Relationship: _____

Emergency Contact Phone#: _____

Primary Care Physician: _____ Phone #: _____

Other doctor's seen regularly: _____ Phone #: _____

_____ Phone #: _____

Who referred you to our practice?

Family Physician / Primary Care Physician (above)

Another Physician _____ Phone #: _____

Other _____

Primary Health Insurance Company

Name of Insurance: _____ Phone #: _____

Address: _____ City: _____ State: _____ ZIP: _____

ID#: _____ Group#: _____

Policy Holder: _____ Date of Birth: _____

Policy Holder's relationship to patient: _____

Secondary Health Insurance Company

Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ ZIP: _____

ID#: _____ Group#: _____

Policy Holder: _____ Date of Birth: _____

Policy Holder's relationship to patient: _____

Please Select: **AUTO INJURY** **WORK INJURY**

Insurance Co Name: _____ Phone #: _____

Claims Address: _____ City: _____ State: _____ ZIP: _____

Claim #: _____ Date of Injury: _____

Adjuster's Name: _____ Phone #: _____ Ext: _____

Rehabilitation Associates of the Main Line, P.C.

1. Consent to Treatment. The Undersigned hereby authorizes, requests and consents to the performance of such services, procedures, medications and other medical treatment to be provided by the physicians and other authorized individuals engaged by Rehabilitation Associates of the Main Line, P.C. ("RAML") as they may believe to be necessary, advisable or beneficial to the health or well being of the patient. This consent extends and applies to the physicians, nurses and other personell engaged by RAML who may provide services to the patient in connection with the care and treatment of the patient. The undersigned recognizes and agrees that the practice of medicine is not an exact science and that no guarantees have been made as to the results of the treatment or examinations by RAML.
2. Consent to Release Medical Records Information. The undersigned hereby acknowledges and agrees that RAML and the physicians supplied by RAML are hereby authorized to disclose all or any part of the patient's medical record and protected health information for the purposes of treatment, payment and health care operations, including but not limited to disclosures to other treating providers and to such insurance companies, organizations or agencies as may be concerned with the payment of the cost of treatments by the physicians and other individuals engaged by RAML.
3. Assignment of Insurance Benefits. The undersigned certifies that the information provided by the patient in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Health Care Financing Administration, the Social Security Administration or its intermediaries or carriers, any information to determine these benefits or the benefits payable for related services. If the patient is a Medicare beneficiary, the undersigned requests that payment of authorized Medicare payments be made on behalf of the patient to RAML, as applicable, and authorizes RAML to submit claims to Medicare for payment to the patient. If the patient is not a Medicare or Medicaid beneficiary, the undersigned expressly authorizes payment directky to RAML for health care benefits otherwise payable to the patient under the terms of the patient's policy. In making such assignment, the undersigned agrees that in consideration for services to be rendered to the patient by RAML, the patient hereby individually obligates himself or herself to promptly pay to RAML any amounts charged by RAML for the services provided by it's physicians or other professionals that are not paid under the patient's insurance policies. The undersigned also agrees that if the nature of the patient's illness or injury is not covered at all by his or her Medicare, Medicaid or other insurance policies, the patient will be responsible to RAML for payment of the entire bill.
4. Insurance Coverages. The undersigned submits that the patient is covered by the insurance policies listed on previous sheet and that, as set forth above, the patient assigns all benefits due to the patient to RAML, as applicable, related to the provision of covered services by RAML to the patient:

the duly authorized legal representative of the patient with authority to execute the above on behalf of the patient and accept its terms.

Date: _____

Print Name of Patient or Authorized Representative: _____

Signature of Patient or Authorized Representative: _____

Witness: _____