

EXCEL REHABILITATION

Patient Registration and Authorization Form

Please Print**Patient Information**

Patient's Name (Last, First, MI)		Patient's Home Phone Number ()	
Address		Patient's Work Phone Number ()	
City	State	Date of Birth	SS#
Zip	Sex	Age	Patient's Employer
Primary Care Physician _____		Phone # () _____	
Referring Physician _____		Phone # () _____	
Type of Injury/ Symptom _____			
Date of injury or first symptom ____/____/____ month date year			
Did injury happen on the job? (YES) (NO) Was injury a result of an Auto Accident? (YES) (NO)			
If yes, when / where? _____			
Please list current medical conditions (including allergies, medications and pregnancy). _____ _____			

INSURED INFORMATION (IF OTHER THAN PATIENT)

Policy Holder _____	Relationship to Patient _____
Social Security Number _____	Date of Birth _____
Employer _____	Work Phone Number _____

INSURANCE INFORMATION*(May we copy your card please?)*

Name of Insurance Company	Address	Subscriber	Policy/ ID#
1. (Primary)			
2. (Secondary)			

FINANCIAL AGREEMENT

The undersigned hereby authorizes the release of any information requested by the insurance company designated above and authorizes payment by such insurance company of medical benefits to EXCEL REHABILITATION for services rendered. The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by EXCEL REHABILITATION whether or not such services are covered by insurance benefits. HMO/PPO plan participants are fully responsible for their designated co-pay and for full coverage of orthopedic appliances and custom orthotics. The undersigned agrees to reimburse EXCEL REHABILITATION for any expenses, including reasonable attorney's fees, incurred in connection with the collection of sums due for services performed hereunder.

Have you contacted your insurance company for verification of benefits? (YES) (NO)
Signature (Financially Responsible) _____ Date _____

WORKMAN'S COMPENSATION CLAIM

A claim will be submitted to your Workman's Compensation Carrier only if the information below is completed. If this information is not available, you will be billed directly until it is supplied. Failure to have claim paid within 90 days without written notification from your carrier that benefits are pending will result in billing the patient directly.

Are we to submit Workman's Compensation? (YES) (NO) Claim number _____

Carrier's Name/Address	Street	City	State	Zip
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Contact Person _____ Phone Number () _____