Print Form

THE REHABILITATION CENTER

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Email: TheRehabCenter@Comcast.net
www.TRCTherapy.com

This form may be filled out "online". Please fill out all information then print, sign and date the 2nd page (In three spots) and bring with you on your first visit!

PATIENT INFORMATION

Last Name | First Name | MI | Nickname

Home Address: Street | City

State | Zip | Home Phone | Cell Phone | Sex

Marital Status | Date of Birth | Social Security Number | E-mail Address

If Married: Spouses Last Name | Spouses First Name | Spouses SSN | Spouses Work Phone

Emergency Contact | Relationship | Phone

How did you hear about our office?

Employer Name | Employer Street Address

Employer City | Employer State | Employer Zip | Employer Phone

INSURANCE INFORMATION

Insurance Company Name | Insurance Company Address

Insurance ID Number | Insurance Group Number

Name of Insured | Relation to Patient

Insurance Employer Name | Insured Employer Address

Employer Phone | Insured Date of Birth | Insured's SSN

2nd Insurance Name | 2nd Insurance ID Number | 2nd Insurance Group Number

PLEASE CONTINUE TO NEXT PAGE

ASSIGNMENT AND RELEASE

I, the undersigned, have secondary insurance coverage with _____
Name of Insurance Company
assign directly to The Rehabilitation Center, Inc., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The Rehabilitation Center, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. If I am a resident of Buckingham Place Assisted Living facility I authorize the release of my medical records to my medical chart located in the health care office of Buckingham Place Assisted Living facility. If I am a participant in the Gallery Day Care program at Buckingham Place Assisted Living facility I authorize the release of my medical records to my medical chart located in the health care office of the Gallery day care program at Buckingham Place Assisted Living facility.

_____ _____
Signature of Insured Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to The Rehabilitation Center, Inc. for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

The Rehabilitation Center has informed me and provided me with a copy of my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Signature of Patient Date

A copy of our Privacy Policy is also available to all our patients "online" at www.TRCTherapy.com under the link "Privacy Policy" at the lower left corner of every page on our website.

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Please remember to fill out all relevant information, then use the print button to print to your local printer. Remember to sign (In three places) and date (in three places) in the Assignment and Release, in the Medicare Authorization, as well as in the Privacy Policy sections on the 2nd Page. Please bring this completed and signed and dated form with you on your first visit to The Rehabilitation Center.