

Accurate Rehabilitation Technologies NEW PATIENT REGISTRATION FORM – PRIVATE PATIENT

(Please Print Clearly)

Today's date:						
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:	Home phone no./Alternate phone no.: () ()		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ()		
Briefly describe symptoms:						
Who were you referred by?:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Please indicate primary insurance		<input type="checkbox"/> CareFirst	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other:	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy/Member ID no.:	Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other	Subscriber's Employer:	
Has your insurance changed since your last visit?					
Do you have a DEDUCTIBLE? <input type="checkbox"/> I don't know <input type="checkbox"/> No <input type="checkbox"/> Yes- How much is it?					
Have you met your DEDUCTIBLE for this year?					
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Accurate Rehabilitation Technologies or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

------(OFFICE USE ONLY) INSURANCE VERIFICATION-----	
Verification completed by:	Date/time of call:
Is Accurate Rehabilitation Technologies "In-Network"? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient need a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
Effective date of policy:	Pre-Cert required? <input type="checkbox"/> No <input type="checkbox"/> Yes- how:
Individual DEDUCTIBLE:	Amount met this year:
DEDUCTIBLE period:	Physical Therapy limitations:
PT visits "allowed" per year:	Visits used this policy year:
Out of pocket Coinsurance: \$ or %:	Co-payment:
If copy of insurance card is not attached, provide CLAIMS ADDRESS:	