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 two 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

PLEASE CONTINUE TO NEXT PAGE

ASSIGNMENT AND RELEASE

I, the undersigned, have 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. I understand that my insurance is a contract between me (or my employer) and my insurance company. The Rehabilitation Center, Inc. is not a party to the contract. Our fees are generally considered to fall within the acceptable range by most insurance companies and therefore may covered up to the maximum allowance determined by each carrier. This does not apply to companies who reimburse based on an arbitrary "schedule of fees" which bears no relationship to the current standard of care in this area. I further understand that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. If I am not sure if a particular service is covered I will verify this with my insurance company. The Rehabilitation Center, Inc. recommends that all patients verify their own benefits before beginning treatment. The Rehabilitation Center, Inc. wishes to emphasize that as medical care providers, our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. I understand and agree that regardless of my insurance status I am ultimately responsible for timely payment for services rendered.

_____ _____
Signature of Patient/Insured 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.

Please remember to fill out all relevant information, then use the print button to print to your local printer. Remember to sign and date the Assignment and Release at the bottom of the 2nd Page along with signing and dating the privacy policy section. Please bring this completed and signed form with you on your first visit to The Rehabilitation Center.

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