



**Patient Information**

Patient Name:	Patient Date of Birth:
Patient Address:	Patient City:
Patient State:	Patient ZIP:
Patient Phone:	Patient Cell Phone:
Patient SSN:	Marital Status:

**Spouse Information**

Spouse Name:	Spouse Date of Birth:
Spouse Employer:	Spouse Phone:

**Patient's Employer Information**

Employer Name:	Employer Phone:
Employer Address:	Employer City:
Employer ZIP:	Occupation:

**Emergency Information**

Contact Name:	Contact Relation:
Contact Phone	Contact Relation:
<b>Referral Source:</b>	<b>Referring Physician:</b>

**Insurance Information**

<b>Primary insurance type:</b> <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS <input type="checkbox"/> Medicare <b>Plan:</b>	
Insurance Policy:	Insurance Group:
Insurance Name:	Insurance Telephone:
Policy holder's Name:	SSN:
Relationship:	Date of Birth:

**Second Insurance Information**

Insurance Policy:	Insurance Group:
Insurance Name:	Insurance Telephone:
Policy holder's Name:	SSN:
Relationship:	Date of Birth:

**Injury Information**

**(ONLY IF THIS IS an Auto Accident OR Work Comp related)**

Injury Date:					
Employ Related:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Auto Related:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Post-Operative:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	W/C Claim:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Accident:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	W/C Claim Number:		

**Worker's Compensation Information**

W/C Carrier:	W/C Phone:
W/C Address:	W/C City & State:

**Attorney Information**

Attorney Name:	Attorney Phone:
Attorney Address:	Attorney City & State:

I hereby authorize **Achieve Orthopedic Rehab Institute** to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to the physician any benefits due me under my insurance plan. I certified that the information above is correct and I understand that any remaining unpaid balance after contractual discounts are taken into consideration will be my responsibility.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Co-Payments Physical Therapy: Co-Payments amounts are specified by the terms of the member's benefit agreement and are the Patient's responsibility at the time of service. These fees are not negotiable. Past due account balances will be addressed prior to service.**



**ACHIEVE ORTHOPEDIC REHAB INSTITUTE**

