RIVER REHABILITATION PATIENT INFORMATION SHEET

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____

Address: _____ Date of injury or onset date: _____/_____/_____

City, State, Zip: _____ Injury due to: ( ) MVA ( ) On the job ( ) Surgery ( ) Chronic ( ) Other

Home Phone (including area code): _____ ( ) Single ( ) Married ( ) Divorced ( ) Widowed
( ) Male ( ) Female

Cell Phone (including area code): _____

Patient's Employer: _____ **Please complete spouse/parent information below. Insurance will not process claims without this information.**

Employer's Address: _____ Spouse/Parent (if patient is still under parent's insurance): _____

City, State, Zip: _____Spouse/Parent's social security no: _____-_____-_____ DOB: _____/_____/_____

Employer's Phone (with area code): _____ Spouse/Parent's Employer: _____ Phone: _____

We provide notification of upcoming appointments. Please provide your preferred form of communication (messaging fees apply, where applicable):

Text (phone number): _____ **Email (email address):** _____

PLEASE PRESENT YOUR INSURANCE CARDS FOR COPYING

( ) Commercial ( ) BCBS ( ) Auto ( ) Workers Comp ( ) Medicare ( ) Medicaid ( ) Other

Primary Insurance: _____ Secondary Insurance: _____

Complete the following section if this is a Motor Vehicle Accident (MVA) or Workers Compensation claim. We must have the claim number.

CLAIM NUMBER: _____ Adjustor's Name & Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Daytime Phone: _____ Cell Phone: _____

I hereby consent to treatment and authorize this medical service provider to furnish my insurance companies, including Medicare, with all information requested relating to my illness or injury. I authorize payment to be made to this medical service provider by commercial or government insurance companies for treatment and supplies provided, not to exceed my indebtedness.

I understand that I am financially responsible to this medical service provider for all expenses incurred, and that my insurance carrier may apply amounts to deductible, copays, and/or coinsurance, for which I will be billed and must pay to this medical service provider. If there is a question regarding the payment or denial of any claims, I understand that I must contact my insurance representative for clarification. I further understand that if there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.

Signature: _____ Date: _____/_____/_____