RIVER REHABILITATION PATIENT INFORMATION SHEET

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

Address: _____ Date of Birth: _____ Date of Onset: _____

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

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Home Phone (including area code): _____

Gender: ( ) Male ( ) Female

Cell Phone (including area code): _____

Patient's Employer: _____ Employer's Address: _____

Employer's Phone (with area code): _____

Please complete spouse/parent information below. Insurance will not process claims without this information.

Spouse/Parent Name (if patient is under spouse/parent insurance): _____

Spouse/Parent Social Security Number: _____ Date of Birth: _____

Spouse/Parent 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 MARK BELOW FOR TYPE OF INSURANCE. PLEASE PRESENT YOUR INSURANCE CARDS FOR COPYING.

( ) Humana ( ) BCBS ( ) Iowa Total Care ( ) Workers Comp ( ) Medicare ( ) Medicaid ( ) Other

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: _____/_____/_____