Quality Care Physical Therapy & Rehab Center, PA

DATE: _____ REFERRING DOCTOR: _____

PATIENT INFORMATION

Last Name_____First_____M.I._____

Address_____Apt#_____

City_____ State_____ Zip Code_____

Home Phone Number_____ Cell Phone Number _____

Date of Birth_____ Sex M____ F____

Social Security number: _____

Marital Status: M_____ S_____ D_____ Spouse's Name_____

Is this a work related injury? Yes_____ No_____ Date of Injury_____

Is this an auto accident related injury? Yes_____ No_____ Is there an attorney involved? Yes___ No____

Are you currently under HOME HEALTH CARE? Yes _____ NO_____

PATIENT WORK INFORMATION

Employer's Name_____

Employer's Address_____

City_____ State_____ Zip Code_____

Work Phone Number_____Extension_____

Employee Id Number_____Occupation_____

PATIENT INSURANCE INFORMATION

Is this your coverage? Yes____ No____ If no, whose name is covered _____

Your relationship to the insured_____ Policy Number_____

Group Number_____ Certificate Number_____

Insurance Company Name_____

Address_____

City_____ State_____ Zip Code_____

Phone Number_____

Patient Name:

SECONDARY INSURANCE INFORMATION

Name of Insured_____Relationship_____
Insurance Policy Number_____ Group Number_____
Insurance Company Name_____ Phone #_____
Ins. Co. Address_____
City_____ State_____ Zip Code_____

AUTO INSURANCE INFORMATION

Name of Insured_____
Auto Insurance Company Name_____
Address_____
City_____ State_____ Zip Code_____
Policy Number_____ Claim Number_____
Adjustor's Name_____ Phone Number_____

WORKER'S COMPENSATION INFORMATION

Employers Name (at time of injury)_____
W/C Insurance Name_____ Phone#_____
Address_____
City: _____State: _____ Zip Code_____
Claim Number_____
Adjustor Name_____ Adjustor Contact: _____

ATTORNEY INFORMATION

Name_____ Phone #_____
Address_____
City_____ State_____ Zip Code_____

AUTHORIZATION TO PAY QUALITY CARE PHYSICAL THERAPY

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to QUALITY CARE PHYSICAL THERAPY and I am financially responsible for non-covered services. I also authorize QUALITY CARE PHYSICAL THERAPY to release any information to process this claim.

SIGNED: _____DATE:_____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I understand that Quality Care Physical Therapy may contact my physician, insurance company and/or employer if I do not arrive for my scheduled treatment. Returned check fee: $25.00 per occurrence.

SIGNED: _____DATE:_____

Patient Name:

CONSENT TO USE AND/OR DISCLOSURE OF PATIENT INFORMATION

As a patient of **Quality Care Physical Therapy & Rehab Center, PA**, you have the right to know how we may use and disclose information about you. Information about this is provided in our Notice of Patient Privacy Practices.

You have the legal right to review our Notice of Patient Privacy Practices before signing this form. A copy of this notice was made available to you along with the consent. If you do not have a copy of the notice you can request one from us at the address and phone number given below.
We may change our Notice of Privacy Practices from time to time. If we do change it, we will make a copy of the revised Notice available to you the next time you come in for an appointment. You may obtain a copy of our current Notice upon request to our address and phone number given below.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your consent to use or disclose information about you so that we can provide you with health care treatment; arrange payment for your care; and conduct certain kinds of administrative health care operations. By signing this Consent below, you agree that we may use or disclose information about you for these purposes.
You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or health care operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing. Please contact us at the address and phone number given below if you want more information or to request additional restrictions.

You have the right to revoke this Consent at any time, but must do so in writing. A revocation of this Consent will not apply to any use or disclosure of information which happened before we received your written revocation. Please contact us at the address and phone number below if you want more information, or to revoke this Consent.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment, and health care operations.

_____

Name of Patient

_____

Patient Signature & Date

Practice Name: Quality Care Physical Therapy & Rehab Center, PA
Practice Address: 1600 Saint Georges Ave, Suite 212, Rahway NJ 07065
Practice Phone:732-669-1000; Fax: 732-669-1001

Patient Name: