PATIENT INFORMATION SHEET

Nat'l Medical Rehabilitation
9400 Livingston Rd, Ste 450 Ft Washington MD 20744
(301) 248-8900 www.rehabmedonline.com

PATIENT INFORMATION:

☐ PRIVATE (not accident related)
☐ AUTO ACCIDENT
☐ WORKER'S COMPENSATION
☐ PERSONAL INJURY CASE

_____
DATE OF INJURY

REFERRED BY:

☐ DOCTOR _____
☐ FRIEND / RELATIVE
☐ GOOGLE/ONLINE SEARCH

NAME: Last	First Name	Middle Initial	Marital Status	Sex
				FEMALE / MALE TRANS / NON-BINARY

DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	STUDENT:
		☐YES ☐NO

HOME ADDRESS:	CITY	STATE	ZIP

HOME PHONE:	EMAIL ADDRESS:	CELL PHONE:	I consent contact to receive APPOINTMENT REMINDERS:
			☐SMS/Text ☐Email

EMPLOYER NAME & ADDRESS:	CITY	STATE	ZIP

RACE

☐ American Indian or Alaska Native	☐ Black or African American	☐ White
☐ Asian	☐ Native Hawaiian or Pacific Islander	☐ Other _____

EMERGENCY CONTACT: NAME	EMERGENCY CONTACT PHONE:

SPOUSE'S OR PARENTS NAME:	DATE OF BIRTH:	

SPOUSE'S OR PARENT'S ADDRESS	CITY	STATE	ZIP

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. INSURANCE AUTHORIZATION: I AUTHORIZED NAT'L MEDICAL REHABILITATION TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ALSO DIRECT THAT SUCH INSURANCE BENEFITS BE PAID DIRECTLY TO NAT'L MEDICAL REHABILITATION FOR SERVICES RENDERED.

CONSENT TO TREAT, ASSIGNMENT OF INSURANCE BENEFITS, AND FINANCIAL RESPONSIBILITY AGREEMENT

A. AUTHORITY FOR TREATMENT
I hereby authorize and consent to all usual and customary care required for consent of my treatment by the medical office of *Nat'l Medical Rehabilitation*. The diagnosis and treatment of my condition, including examinations, tests, and procedures, are ordered by my physician. I acknowledge that no guarantee has been made to me as to the effect of such examinations or treatment of my condition.

B. ASSIGNMENT OF INSURANCE BENEFITS
I hereby assign to the medical office of *Nat'l Medical Rehabilitation* all insurance benefits including automobile, health, homeowners, or PIP benefits (if applicable) that are payable for services rendered. I also direct that such insurance benefits be paid directly to *Nat'l Medical Rehabilitation* for services rendered. I consent to the release of any medical information that may be required to verify any claim made as a result of these services.

C. FINANCIAL RESPONSIBILITY AGREEMENT
I accept responsibility for payment to *Nat'l Medical Rehabilitation* for all services covering the treatment of the above-named patient. If payment is not made and additional collection efforts are required, I hereby agree to pay all bills rendered for the said patient together with any and all collection costs, pre-judgment interest at a rate of 6% per annum from the last date of treatment, and reasonable attorney's fees of 35% of the balance due. I understand that all bills are payable and become due upon presentation.

_____ _____
SIGNATURE (patient, or parent/guardian if under 18) **TODAY'S DATE**

_____ _____
PERSONAL REPRESENTATIVE (print name & relationship, affix signature) TODAY'S DATE

Modification of the above Financial Responsibility Agreement forfeits all responsibility of Nat'l Medical Rehabilitation to treat the patient.

Nat'l Medical Rehabilitation
9400 Livingston Rd, Ste 450 Ft Washington MD 20744
(301) 248-8900 www.rehabmedonline.com

PRIVATE INSURANCE OR PERSONAL INJURY CASE (PI)

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE OF INJURY:**_____

PRIMARY INSURANCE CARRIER NAME & ADDRESS:	CITY	STATE	ZIP

INSURANCE TELEPHONE #:	FAX #:	ADJUSTER NAME (if any)

MEMBER I.D. NUMBER:	**GROUP #:**	**CLAIM #:**	**POLICY EFFECTIVE DATES:**

POLICY HOLDER: NAME & ADDRESS:	POLICYHOLDER DOB & Relationship:	
		☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE NAME & ADDRESS:	CITY	STATE	ZIP

2ND INSURANCE I.D. NUMBER:	**GROUP #:**	**PHONE #:**	**POLICY EFFECTIVE DATES:**

2nd INSURANCE POLICY HOLDER: NAME, & ADDRESS:	BIRTHDATE	RELATIONSHIP
		☐ Self ☐ Child ☐ Spouse ☐ Other

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. INSURANCE AUTHORIZATION: I AUTHORIZED NAT'L MEDICAL REHABILITATION TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ALSO DIRECT THAT SUCH INSURANCE BENEFITS BE PAID DIRECTLY TO NAT'L MEDICAL REHABILITATION FOR SERVICES RENDERED.

CONSENT TO TREAT, ASSIGNMENT OF INSURANCE BENEFITS, AND FINANCIAL RESPONSIBILITY AGREEMENT

A. **AUTHORITY FOR TREATMENT**
I hereby authorize and consent to all usual and customary care required for consent of my treatment by the medical office of *Nat'l Medical Rehabilitation*. The diagnosis and treatment of my condition, including examinations, tests, and procedures, are ordered by my physician. I acknowledge that no guarantee has been made to me as to the effect of such examinations or treatment of my condition.

B. **B. ASSIGNMENT OF INSURANCE BENEFITS**
I hereby assign to the medical office of *Nat'l Medical Rehabilitation* all insurance benefits including automobile, health, homeowners, or PIP benefits (if applicable) that are payable for services rendered. I also direct that such insurance benefits be paid directly to *Nat'l Medical Rehabilitation* for services rendered. I consent to the release of any medical information that may be required to verify any claim made as a result of these services.

C. **C. FINANCIAL RESPONSIBILITY AGREEMENT**
I accept responsibility for payment to *Nat'l Medical Rehabilitation* for all services covering the treatment of the above-named patient. If payment is not made and additional collection efforts are required, I hereby agree to pay all bills rendered for the said patient together with any and all collection costs, pre-judgment interest at a rate of 6% per annum from the last date of treatment, and reasonable attorney's fees of 35% of the balance due. I understand that all bills are payable and become due upon presentation.

_____ _____
SIGNATURE (patient, or parent/guardian if under 18) TODAY'S DATE

_____ _____
PERSONAL REPRESENTATIVE (print name & relationship, affix signature) TODAY'S DATE

Nat'l Medical Rehabilitation
9400 Livingston Rd, Ste 450 Ft Washington MD 20744
(301) 248-8900 www.rehabmedonline.com

PAIN / INJURY HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____☐AM☐PM

Place of Accident: _____ Referred By: Dr. _____

Sex: ☐Male ☐Female Age: _____ Height: _____ Weight: _____ Are you currently working? ☐Yes ☐No

Date you stopped work: _____ Job Position: _____

What caused your pain? If an accident, describe what happened to you at the time of the accident _____

_____

_____

Rate your pain 0-10 (0 being NO pain - 10 being very severe): 10 - Unbearable Pain **9 10**

Location of Pain:

☐ Neck ☐ Shoulders
☐ Upper back ☐ Lower back
☐ Upper Thoracic ☐ Lower Thoracic
☐ Any numbness? Where? _____
☐ Upper Extremities Pain? Where?: _____
☐ Lower Extremities Pain? Where? _____

Were you:

☐ Hit head on _____
☐ Dizziness / Lightheaded
☐ Passed out ☐ Nausea
☐ Headaches ☐ Double Vision

A. IS THIS A CAR ACCIDENT INJURY ? (check if applicable) ☐YES ☐NO

☐ Driver ☐ Passenger ☐ Wearing Seatbelt ☐ No Seatbelt
☐ Your vehicle ☐ Moving Collision ☐ Front-End Collision ☐ Rear-End Collision

B. TREATMENTS AND TESTS RECEIVED (check if applicable)

☐ Admitted to the Emergency Room? Hospital Name: _____
☐ Admitted to the hospital? Hospital Name: _____
☐ Seen by a physician? Name, Phone # of Dr. _____
☐ Test(s) done – (X-ray, MRI, blood test)? _____ Where? _____

C. PAST HISTORY

☐ Surgeries? When? _____
☐ Fractures? When? _____
☐ Previous motor vehicle accident? Date_____
☐ Previous WorkComp accident? Date _____
☐ Drug Allergies? Please List _____

D. History of any of the following medical condition(s):

☐ High blood pressure
☐ Heart Problem(s)
☐ Diabetes
☐ Arthritis
☐ Gout

E. MEDICATIONS

List all PAIN medications and doses you are currently taking:

Prescribed by: _____
Telephone # & Clinic Name: _____
1. _____ Dose_____
2. _____ Dose_____
3. _____ Dose_____

Mark on the picture below where you have or have had pain symptoms since your injury. Include symptoms of numbness or tingling sensations.