Pro Fit Rehab

Patient Personal Information

Date:_____

OFFICE USE ONLY

Patient Name:_____ DOB: _____

Home Phone:_____ Cell: _____ SS#: _____

Referring Physician: _____ Diagnosis: _____ Sex: _____

Patient Information

Patient Name		Home Phone	Cell Phone	
Address		City	State	Zip
Marital Status	Spouse Name	SS#/DOB	Email Address	

Insured Information if Different from Patient

Insured Name	DOB	ID#

Is this Visit a Result of: An injury at work?_____ If yes, please fill out below.

Employer Name	Contact Person	Phone Number

Employment Information

Employer Name (Full or Part-time)	Work Phone		
Address	City	State	Zip

Primary Care Physician Information

Primary Care Physician	Phone

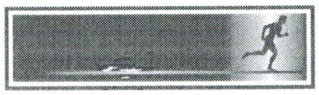
Emergency Contact Information – Not living at the same address

Name	Relationship	Best Number to Reach

OFFICE USE ONLY

Insurance Policy Information

Primary Insurance		Phone		Secondary Insurance
Policy Holder's Name		Policy Holders DOB		Group #
Group #	ID/ Sub #	Relation to Patient		ID/ Sub #



Pro Fit Rehab

Patient Personal Information

Date:_____

Effective Date of Policy:_____ Is Authorization Required: **YES** or **NO**

Benefits Paid at:_____ Deductible _____ Met:_____ Remaining:_____

Co-Pay:$_____ Co Ins:_____ No Auth Visits (Original):_____ #Remaining:_____

Assignment of Benefits:
I directly assign all my benefits, including major medical benefits and Medicare, to Pro Fit Rehab of Charlotte, PA. I understand that this authorization for assignment remains in effect until I revoke it in writing. A photocopy of this assignment will be considered as valid as this original assignment. I further understand that I am responsible for all incurred charges.

Authorization to Receive Therapy:
I hereby authorize treatment to be rendered by Pro Fit Rehab of Charlotte, PA as prescribed by my physician.

Authorization to Release Information:
I hereby authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me to release any such information needed to determine these benefits or the benefits payable for related services.

BY VIRTUE OF MY SIGNATURE, I have read and agree to the above acknowledgment/authorizations.

Insured or Guardian's Signature_____ **Date:**_____