NEW PATIENT REGISTRATION FORM

Patient's Name____
Last First Middle Initial
Street Address____
City State Zip
Mailing Address____
City State Zip
Home Phone_______________________________ Work Phone___________________________
Cell Phone _______________________________ Email Address_________________________
Date of Birth_____________________________ Social Security #______________________
Sex ☐ Male ☐ Female Driver's License Number____________________
Patient's Status ☐ Single ☐ Married ☐ Other Date of Injury__________________

Are you currently receiving ANY Home Health Services ☐ Yes ☐ No

Employer/Company at time of injury:
Name____Phone#:____________________
Street Address____
City State Zip

HOW DID YOU HEAR ABOUT GREAT NORTHERN REHAB? ☐ Doctor ☐ Friend/Relative ☐ Advertisement ☐ Phone Book ☐ Other______________________

WHO MAY WE CONTACT IN CASE OF EMERGENCY?

Name_______________________________________ Phone Number_________________________
Relationship_________________________________

INSURANCE INFORMATION (check one please) ☐ MC ☐ Tricare/Champus ☐ Auto ☐ BC/BS

Subscriber's Name_____________________________ ☐ WC ☐ AvMed ☐ HPSE ☐ Cigna
SS #______________________ DOB______________________
Insurance Name____
Street Address____
City State Zip
Subscriber's Number__________________________ Group Number_______________________
Employer Name____
Street Address____
City State Zip
Secondary Insurance____

AUTHORIZATION FOR TREATMENT

I authorize Great Northern Rehab, its employees and agents as well as any and all independent contractors engaged by Great Northern Rehab to perform the services on my behalf as they may deem necessary.

Signature_____________________________________ Date_______________________________

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We feel strongly that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

PLEASE READ AND INITIAL THE FOLLOWING:

______ I authorize this office to release or receive any information necessary to expedite insurance claims

______ I hereby authorize this office to bill my insurance company directly for their services

______ I authorize payment directly to this provider of my insurance benefits otherwise payable to me

______ In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable

______ I hereby authorize the Great Northern Rehab physical and occupational therapist (s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize Great Northern Rehab to perform any service (evaluation, treatment procedures, and testing) necessary for my rehabilitation

______ Great Northern Rehab is granted permission to release to the insurance carrier, employer, attorney, their representatives or referring physician, any information in connection with any treatment rendered to patient or on patient's behalf at any time such information is requested.

______ **HIPAA** I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I understand that I am directly and completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee.

A Photostat copy of these authorizations and agreements shall be as valid as the original.

______________________________	______________________________	__________
Patient or Guardian (print)	Patient or Guardian (signature)	Date