

Today's Date

Account Number

Referring Physician:

Telephone#

Name: Last First Middle

Address: Zip Code:

Telephone: Birth Date: M/F

Employer: SSN#

Employer's Address: Telephone:

Spouse's Name:

Spouse's Employer: Telephone:

Name of person not living with you to contact in case of emergency: Their Telephone:

INSURANCE INFORMATION:

Primary Insurance: Group# ID/SSN

Telephone: Name of Insured:

Address:

Secondary Insurance: Group# ID/SSN

Telephone: Name of Insured:

Address:

COMPLETE ONLY IF USING MEDICAL COUPONS Are you eligible for assistance through the Dept. of Social & Health Services? Yes No
 If yes, have you had any physical therapy within the calendar year? Yes No

COMPLETE ONLY IF ON THE JOB INJURY:

State in which Injury Occurred:

Employer at time of Injury: Date of Injury:

Insurance Company: Telephone:

Address:

Claim Adjuster: Claim#

Complete "ONLY" if auto accident: Check to Bill "MY" Insurance or "OTHER" responsible party State Injured In:

Insurance Company: Telephone:

Address:

Claim Adjuster: Claim# Date of Injury:

Name of Insured: Relationship to Insured:

Please Note: Even though, you the patient, may not be at fault with regard to this motor vehicle accident, it is best to bill your insurance company. They in turn will recover funds from the responsible party. Vancouver Rehabilitation & Therapy Clinic will bill the insurance company twice monthly.

Would you like to receive a monthly statement? _____

If an attorney is handling your claim, either motor vehicle or on the job injury, please give the following information:

Attorney's Name: Address: Telephone:

Welcome to our office. Our staff is here to help you obtain the care you need in a pleasant and efficient manner. In the interest of good medical practice, it is important to establish a credit policy to avoid misunderstandings. WE WILL BILL ALL INSURANCE COMPANIES DIRECTLY if we have pertinent billing information. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE for services rendered. I authorized my insurance carrier to pay benefits directly to VANCOUVER REHABILITATION & THERAPY CLINIC. If balance becomes delinquent, I agree to pay all collection costs. Accounts over 60 days may be subject to a monthly finance charge of 1% of the unpaid balance, UNLESS financial arrangements have been made prior. I authorize release of medical information to my insurance company and assign all benefits to VANCOUVER REHABILITATION & THERAPY CLINIC.

Signature of Patient or person assuming financial responsibility _____ Date: _____