

Neuro Rehab Associates, Inc.

Patient Information- Work Comp Claims

PATIENT (LEGAL) NAME: _____ AGE: _____ BIRTHDATE: _____

SEX: M / F SSN: _____ PHONE: _____ CELL: _____

EMAIL ADDRESS _____ Would you like us to text or email (circle one) you appointment reminders? Yes No

PHYSICAL ADDRESS: _____
City State Zip

MAILING ADDRESS: _____

EMPLOYER: _____ PHONE: _____

SPOUSE NAME: _____ SPOUSE DOB: _____ PHONE: _____

May we discuss information regarding your bill, treatment, schedule with your spouse? Circle all that apply. Yes No

PHYSICIAN ORDERING THERAPY: _____

How did you hear about us? _____

WORK COMP BILLING INFORMATION

WORK COMP CARRIER: _____ CLAIM NUMBER: _____

ADDRESS: _____ PHONE: _____

CLAIMS ADJUSTER: _____ PHONE: _____

DATE OF INJURY: _____ EMPLOYER AT TIME OF INJURY: _____

ATTORNEY: _____ PHONE: _____

SHOULD THE WORK COMP INSURANCE DENY LIABILITY FOR THE CHARGES, WE CAN BILL YOUR PRIVATE INSURANCE

(Please note: Please provide your private insurance information and/or a copy of your Insurance Card)

POLICY HOLDER NAME: _____ DOB: _____ RELATION: _____

INSURANCE COMPANY: _____ ID/CLAIM #: _____ GROUP#: _____

PLEASE READ- IMPORTANT INFORMATION

- 1) I consent to examination, treatment and procedures that may be performed during office visits considered necessary by the therapist.
- 2) I authorize **Neuro Rehab Associates, Inc.** to request information from my attending physician, vocational rehabilitation, employer, and/or insurer if needed.
- 3) I authorize the release of medical information to my insurance company and to such other persons/organizations (listed below) as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA).
- 4) I understand that should my Work Comp Insurance deny liability for these charges, I am financially responsible.
- 5) I authorize and request that any insurance benefits be paid directly to **Neuro Rehab Associates, Inc.**
- 6) I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs, will be added to the balance of my account.
- 7) Per HIPAA regulations, I acknowledge that this office has a posted notice available in the patient reception area. A copy of available by request and is on the Neuro Rehab Associates website- www.boztherapy.com. We will not disclose your health information without your authorization, except as described in this notice.

Attending Physician: _____ Vocational Rehab Counselor _____

Insurer/Insurer Representative: _____ Employer: _____

SIGNATURE OF RESPONSIBLE PARTY

DATE