

Active Rehab Center, Inc.

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PHYSICAL THERAPY AND MASSAGE CLINIC

Referring Physician's Name: _____ Diagnosis: _____

Patient Information:

Patient's Name: Last: _____ First: _____ M ___

Address: _____ DOB: _____

_____ Cell # _____

(City) (State) (Zip)

Patient's E-Mail: _____ Home Ph #: _____

Marital Status (circle one): Single Married Divorced Widowed Separated

Emergency Contact: _____ Tel: _____

INSURANCE INFORMATION: Is it Auto or Work Related? YES ___ NO ___ Injury Date: _____

MEDICARE, BC/BS, BCN, Meridian, UHC, HAP, AETNA, AUTO, Workman's Comp, Other: _____

Card Holder Name: _____ Employer: _____

Card Holder DOB: _____ Policy ID # _____ Tel: _____

Secondary Insurance (if applicable) _____ Policy ID # _____

1 Do you currently receive any home health services? (Medicare Patients only) Yes No

2 Have you received any other physical therapy services this year? Yes No. If Yes, how many visits? _

3 Do you have any other medical insurance? (Auto, Worker's Comp, Other _____) Yes No

If Yes, please provide name & address: _____

Claim # _____ Adjuster Name: _____ Tel: _____

I assign directly to Active Rehab Center, Inc. all physical therapy and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible to render money received to Active Rehab Center, Inc. I hereby authorize Active Rehab Center, Inc. to release all information necessary to secure the payment of benefits. Photocopies of this form are to be valid as original. I understand that I am fully responsible for all service charges including but not limited to deductibles, co-pays, co-insurance, partially paid or other types of unpaid services.

How have you heard about us?

Referred by Doctor ___ Friend ___ Family ___ Facebook ___ Internet ___ Returning ___ Other _____

If you are unable to keep your visit, please inform us at least 24 hours ahead to avoid a \$25.00 cancellation fee. It will give a chance to offer the appointment to our awaiting patients. Out of respect and consideration for other patients and our therapists, please plan your therapy visits accordingly. Thank you for your kindness and understanding.

Patient's Signature: _____ Date: _____

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www.activerehabcenter.com