DOUGLAS RAPID REHAB™

CONFIDENTIAL PATIENT INFORMATION

NAME _____ SOCIAL SECURITY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARTIAL STATUE _____ # OF CHILDREN _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ OCCUPATION _____

WORK ADDRESS _____

EMAIL ADDRESS _____

REFERRED BY _____

SPOUSE'S NAME _____ SPOUSE'S WORK PHONE _____

NEAREST RELATIVE'S PHONE _____ RELATIONSHIP _____

OFFICE POLICY

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT POLICIES ARE AN AGREEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED PAID DIRECTLY TO THIS OFFICE WILL BE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE; AND IF PAYING BY CREDIT CARD I AUTHORIZED **RAPID REHABILITATION, INC.** TO PUT MY BALANCE THOUGHT ACCORDINGLY. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND AGREE THAT 1.5% MONTHLY FINANCE CHARGES MAY BE ADDED TO MY ACCOUNT OVER 30 DAYS. IN THE CASE OF A DELINQUENT ACCOUNT, I UNDERSTAND THAT I AM RESPONSIBLE FOR ATTORNEY'S FEES AND COLLECTION FEES. I UNDERSTAND AND AUTHORIZE **RAPID REHABILITATION, INC.** TO OBTAIN ANY PRIOR MEDICAL RECORDS OR ASSIST ME IN MY CARE AND TREATMENT IN THIS OFFICE.

PLEASE CHECK METHOD OF PAYMENT:

CASH _____ CHECK _____ CREDIT CARD _____

PATIENT SIGNATURE _____ DATE _____