To Integrated Rehabilitation Center Patients:

Integrated Rehabilitation Center is dedicated to providing you with the highest quality of healthcare services. To keep the registration process as smooth as possible, please be aware of the following guidelines:

- Please bring your medical insurance card with you if and when there has been any change or update to your health insurance policy. We will make a photocopy for our records and update your file.

- If your health insurance requires a co-payment to see a physician, it MUST be paid at the time of your appointment. If you cannot make the co-payment at the time of your appointment, we may ask that you please make arrangements with us ahead of time.

- If you are unable to keep a scheduled appointment in the future, please call at least 24 hours in advance to cancel the appointment so that someone else who needs to be seen can be scheduled in your place.

- A charge of $25.00 will be assessed if 24-hour notice to cancel a scheduled massage appointment has not been received. Regular office visits can be made up during that week; however, you must follow your prescribed treatment plan. You will be personally responsible for payment of this fee, as any insurance you may have does not cover it.

Signing below acknowledges that you understand these guidelines and were given a copy of the NOTICE OF PRIVACY PRACTICES in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Please ask to speak with the office administrator if you have any questions or concerns. Thank you very much for your cooperation.

_____
Patient Name (Print)

_____ _____
Patient Signature (Parent or Legal Guardian, if patient is a minor) Date

Integrated Rehabilitation Centers

OFFICE USE:
ACCOUNT NUMBER_____ DATE OF FIRST OCCURRENCE_____

Patient Registration Form

PATIENT

Legal Name: Last	First	Middle Initial	Social Security #
Street Address	Apartment #		Birth Date
City	State	Zip	Martial Status **M S D W** / Are you a student? No Yes (part-time) Yes (full-time)
Home Phone	Work Phone	Extension	Occupation
Date	Emergency Contact	Phone #	Relationship
Employer	Employer Address: Street	State	Zip

SPOUSE / PARENT

Legal Name: Last	First	Middle Initial	Social Security #
Street Address	Apartment #		Birth Date
City	State	Zip	E-mail
Home Phone	Work Phone	Extension	Cell Phone
Employer	Employer Address: Street	State	Zip

PRIMARY INSURANCE

Insurance Name			
Address			Effective Date
City	State	Zip	Telephone #
Subscriber Name		Birth Date	Patient's Relationship to Subscriber (circle one) **SELF SPOUSE CHILD OTHER**
Policy/ Contract #	Group #		Subscriber's Employer

SECONDARY INSURANCE

Insurance Name			
Address			Effective Date
City	State	Zip	Telephone #
Subscriber Name		Birth Date	Patient's Relationship to Subscriber (circle one) **SELF SPOUSE CHILD OTHER**
Policy/ Contract #	Group #		Subscriber's Employer

TERTIARY INSURANCE

Insurance Name			
Address			Effective Date
City	State	Zip	Telephone #
Subscriber Name		Birth Date	Patient's Relationship to Subscriber (circle one) **SELF SPOUSE CHILD OTHER**
Policy/ Contract #	Group #		Subscriber's Employer

OFFICE USE:
ACCOUNT NUMBER_____ DATE OF FIRST OCCURRENCE_____

Patient Registration Form

Primary Care Physician

Physician's Name		UPIN	Date Last Seen
Street Address	Suite #		
City	State	Zip	
Office Phone	Fax	Specialty	Specialty Code

Referring Physician

Physician's Name		UPIN	Consult Date
Street Address	Suite #		
City	State	Zip	

Office Phone	Fax	Specialty	Code 1	Code 2	Code 3

Financial Responsibility

I understand that my payment is expected at the time of service. This includes, but is not limited to, coinsurance, co-payment, deductible, and non-covered services. I promise to pay all costs of collection, including reasonable attorneys' fees and collection agency costs that may be incurred in the collection of any and all indebtedness due to (_____).

_____

Patient/Legal Guardian/Relative Signature Date Legal Guardian/Relative Relationship

_____ _____

Witness Date Witness Date

Integrated Rehabilitation Centers

OFFICE USE:
ACCOUNT NUMBER_____ DATE OF FIRST OCCURRENCE_____

Patient Registration Form

Eligibility Status 1

Primary Insurance Name	Patient Name			Effective Date
Paper Claims Mailing Street Address	Group Name/Number	Subscribers ID Number		Plan
City State Zip	Deductible Amount **$**	Amount Applied to Deductible **$**	Co-Insurance **%**	
Contact Information:	Co-Pay Amount **$**	Number of Sessions Allowed	Number of Sessions Used	
Telephone Number	Identify Pre-Existing Condition Clause		Pre-Certification Required **Yes**_____ **No**_____	
Electronic Claims Submissions Payor ID# /Network ID#	Subscribers Name		Subscriber Social Security #	

Eligibility Status 2

Secondary Insurance Name	Patient Name			Effective Date
Paper Claims Mailing Street Address	Group Name/Number	Subscribers ID Number		Plan
City State Zip	Deductible Amount **$**	Amount Applied to Deductible **$**	Co-Insurance **%**	
Contact Information:	Co-Pay Amount **$**	Number of Sessions Allowed	Number of Sessions Used	
Telephone Number	Identify Pre-Existing Condition Clause		Pre-Certification Required **Yes**_____ **No**_____	
Electronic Claims Submissions Payor ID# /Network ID#	Subscribers Name		Subscriber Social Security #	

FOR OFFICE USE ONLY:

BENEFITS CHECKED BY: _____

BENEFITS CHECKED DATE: _____

NOTES/COMMENTS: