



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

ACCOUNT NUMBER \_\_\_\_\_ OFFICE USE:  
DATE OF FIRST OCCURRENCE \_\_\_\_\_

## Patient Registration Form

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

<b>SPOUSE / PARENT</b>	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

<b>PRIMARY INSURANCE</b>	Insurance Name					
	Address					Effective Date
	City	State	Zip	Telephone #		
	Subscriber Name			Birth Date	Patient's Relationship to Subscriber (circle one) <b>SELF SPOUSE CHILD OTHER</b>	
	Policy/ Contract #		Group #		Subscriber's Employer	
<b>SECONDARY INSURANCE</b>	Insurance Name					
	Address					Effective Date
	City	State	Zip	Telephone #		
	Subscriber Name			Birth Date	Patient's Relationship to Subscriber (circle one) <b>SELF SPOUSE CHILD OTHER</b>	
	Policy/ Contract #		Group #		Subscriber's Employer	
<b>TERTIARY INSURANCE</b>	Insurance Name					
	Address					Effective Date
	City	State	Zip	Telephone #		
	Subscriber Name			Birth Date	Patient's Relationship to Subscriber (circle one) <b>SELF SPOUSE CHILD OTHER</b>	
	Policy/ Contract #		Group #		Subscriber's Employer	

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## Patient Registration Form

<b>Primary Care Physician</b>	Physician's Name		UPIN		Date Last Seen	
	Street Address		Suite #			
	City		State		Zip	
	Office Phone	Fax	Specialty		Specialty Code	
<b>Referring Physician</b>	Physician's Name		UPIN		Consult Date	
	Street Address		Suite #			
	City		State		Zip	
	Office Phone	Fax	Specialty	Code 1	Code 2	Code 3

<b>Financial Responsibility</b>	<p>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 _____.</p>					
	Patient/Legal Guardian/Relative Signature		Date		Legal Guardian/Relative Relationship	
	Witness		Date		Date	
	Witness		Date		Date	

# Integrated Rehabilitation Centers

ACCOUNT NUMBER \_\_\_\_\_ DATE OF FIRST OCCURRENCE \_\_\_\_\_ OFFICE USE:

## Patient Registration Form

<b>Eligibility Status 1</b>	<b>Primary Insurance Name</b>	Patient Name		Effective Date
	<b>Paper Claims Mailing Street Address</b>	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
	<b>Telephone Number</b>	Identify Pre-Existing Condition Clause		Pre-Certification Required Yes _____ No _____
	<b>Electronic Claims Submissions Payor ID# /Network ID#</b>	Subscribers Name		Subscriber Social Security #

<b>Eligibility Status 2</b>	<b>Secondary Insurance Name</b>	Patient Name		Effective Date
	<b>Paper Claims Mailing Street Address</b>	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
	<b>Telephone Number</b>	Identify Pre-Existing Condition Clause		Pre-Certification Required Yes _____ No _____
	<b>Electronic Claims Submissions Payor ID# /Network ID#</b>	Subscribers Name		Subscriber Social Security #

FOR OFFICE USE ONLY:

BENEFITS CHECKED BY: \_\_\_\_\_

BENEFITS CHECKED DATE: \_\_\_\_\_

NOTES/COMMENTS:

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