REHABILITATION SERVICES OF TIFTON, INC.

PATIENT INFORMATION

PLEASE PRINT NEATLY IN INK

CHART #_____ DATE_____

☐ NEW ☐ RESTART ☐ RST ☐ LYMPH THERAPIST_____

PATIENT'S NAME (Last, First MI):_____

ADDRESS:_____ **CITY, ST:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____

SSN:_____ **DATE OF BIRTH:**_____ **AGE:**_____

GENDER: ☐ Male ☐ Female **MARITAL STATUS:** ☐ Married ☐ Divorced ☐ Single ☐ Widowed

STUDENT: ☐ No ☐ Part time ☐ Full time **Name of school**_____

EMPLOYMENT STATUS: ☐ Employed ☐ Disabled ☐ Retired ☐ Other_____

EMPLOYER:_____ **CITY:**_____

(If you are under 18 or are a student, list parent's employment information.
If you are unemployed, list spouse's employment information.)

EMPLOYMENT INFORMATION IS FOR: ☐ Patient ☐ Parent ☐ Spouse

WORK PHONE:_____

SPOUSE'S / PARENT'S NAME:_____ **PHONE:**_____

EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____ **PHONE:**_____

EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____ **PHONE:**_____

REFERRING PHYSICIAN:_____ **DIAGNOSIS:**_____

_____

INJURED ON JOB: ☐ Yes ☐ No

AUTO ACCIDENT: ☐ Yes ☐ No **DATE OF INJURY:**_____

SCHOOL SPORTS INJURY: ☐ Yes ☐ No ***OR*** **DATE OF FIRST SYMPTOM:**_____

ACCIDENT DETAILS:_____

_____

_____

_____

CONTINUED ON BACK →

COVERAGE TYPE: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Work comp ☐ Cash ☐ Other_____

	PRIMARY INSURANCE	*SECONDARY INSURANCE*
INS CO NAME		
POLICY ID #		
INSURED'S NAME		
INSURED'S DOB		
INSURED'S EMPLOYER		
PATIENT'S RELATIONSHIP TO INSURED	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other

INDICATE METHOD OF PAYMENT FOR TREATMENT (deductibles, copays, coinsurance, supplies, non-covered items):

☐ Cash ☐ Check ☐ Visa / Mastercard

HOW DID YOU HEAR ABOUT US?

☐ Doctor ☐ Insurance company ☐ Internet

☐ Family / Friend ☐ Phone book ☐ Other_____

CONSENT FOR TREATMENT

I hereby authorize Rehabilitation Services of Tifton, Inc. / Orthopedic & Sports Physical Therapy, Inc. to provide physical therapy, occupational therapy, speech therapy, or athletic training, including treatment or tests that are deemed appropriate by the physician for the patient whose name appears on this form.

RELEASE OF INFORMATION

I hereby authorize Rehabilitation Services of Tifton, Inc. / Orthopedic & Sports Physical Therapy, Inc. to release any/all information, reports, and/or copies of records necessary to process insurance, etc. to my health insurance company, Medicare, Medicaid, and/or workers' compensation.

ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF ACCOUNT

I hereby authorize direct payment to Rehabilitation Services of Tifton, Inc. / Orthopedic & Sports Physical Therapy, Inc. the benefits herein specified and otherwise payable to me. **I understand that I am ultimately financially responsible for the charges** to all parties not covered by this assignment and/or third parties, etc. **I hereby guarantee payment of all charges incurred by the patient identified on this form.** If filing under workers' compensation, I understand that if my claim is denied, I will be responsible for all charges.

ACCURACY OF INFORMATION

I have answered these questions as accurately as possible and warrant that the information on this form is true and correct to the best of my knowledge.

_____ _____

Signature of patient or authorized legal representative

Date

REHABILITATION SERVICES OF TIFTON, INC.

"Committed to Excellence"

To:_____

I hereby authorize you to release to Rehabilitation Services of Tifton, Inc. any information including the diagnosis, test, and record of any treatment or examination rendered to me.

Patient's name:_____

Patient's date of birth:_____

_____ _____

Signature of patient or authorized legal representative

Date

_____ _____

Relationship to patient

Witness signature

1488 Old Ocilla Road • P.O. Box 7508 • Tifton, GA 31793 • 229-386-5200 • Fax: 229-386-1412

REHABILITATION SERVICES OF TIFTON, INC.

"Committed to Excellence"

Receipt of Our Notice of Privacy Practices

Rehabilitation Services of Tifton, Inc. Notice of Privacy Practices provides information about how we use and disclose protected health information about you. As provided in our notice, the terms of it may change. If changes are made, we will post the revised notice in a clear and prominent place in our rehabilitation clinic so you will be able to read it. You will be provided a copy of the revised notice upon request.

By signing below, you acknowledge that you have **received** a copy of our Notice of Privacy Practices on the date indicated below.

_____ _____

Signature of patient or authorized legal representative

Date

This receipt of notice will be kept on file at Rehabilitation Services of Tifton, Inc.

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