

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Spouse's Name: \_\_\_\_\_

Preferred Language: English\_\_ Spanish\_\_ Other \_\_\_\_\_

Ethnicity: Hispanic\_\_ Non Hispanic\_\_ Unknown\_\_ Declined \_\_\_\_\_

Race: Caucasian \_\_ Hispanic \_\_ African American \_\_ Asian \_\_ Other \_\_\_\_\_ Declined \_\_\_\_\_

Employer: \_\_\_\_\_ Last Date Worked: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary** Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

**Secondary** Insurance Company : \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Consent To Treat

I consent to any medical treatment rendered as a patient under the general or special instructions of Medical Rehabilitation Specialists.

### Co-Pays / Assignment of Insurance Benefits

I authorize direct payment of medical benefits to Medical Rehabilitation Specialists (MRS) for services rendered. I understand that MRS will file a claim with my insurance company on my behalf, but that I will be held responsible for copays and payments on my account regardless of my insurance coverage or my insurance authorization (unless my condition is covered through a valid workers' compensation claim). If my account becomes delinquent I understand that my account will be forwarded to an outside collection agency. I will be responsible for all costs of the collection process to include legal fees.

I also authorize the release of any medical information regarding my physical condition, in the possession of MRS or any other medical provider, which may be requested in order to process claims for MRS and/or for my care.

\_\_\_\_\_  
(Signature of Patient / Parent or Guardian of Minor) Date \_\_\_\_\_

### Electronic Pharmacy Access

I hereby give permission for MRS to electronically access my pharmacy records from my pharmacy. \_\_\_\_\_ (Initial)

Name and location of pharmacy \_\_\_\_\_