VANCOUVER
Rehabilitation & Therapy
CLINIC, P.S.

Today's Date: _____

PATIENT DEMOGRAPHICS: **Referring Physician:** **Telephone:**

Patient: Marital Status: M / S

Address: Sex: M / F
Street City State Zip

Telephone: Work Cell:

Birth Date: **SS#** **Email:**

Employer: Occupation:

Address: Telephone:

Parent or Legal Guardian *(If a minor or under legal guardianship)* Relationship:

Emergency Contact: Relationship Telephone:

Have you had any **Physical/Occupational Therapy** this calendar year ? ☐ Yes ☐ No

If Yes, Name of Therapy Office: Telephone:

INSURANCE INFORMATION:

Primary Insurance: ID: Group#

Name of Insured: Insured Birthday:

Secondary Insurance: ID: Group#

Name of Insured: Insured Birthday:

WORK COMP INFORMATION *(For On The Job Injury ONLY)*: State in which Injury Occurred: Date if Injury:

Insurance Company: Telephone:

Address:

Claim Adjuster: Claim#

AUTO ACCIDENT INSURANCE *(For Auto Accident ONLY)*: State in which Injury Occurred: Date if Injury:

PIP Insurance Company: Telephone:

Claim Adjuster: Claim#

Name of Insured: Relationship:

If an attorney is handling your claim, either motor vehicle or on the job injury, please give the following information:

Attorney's Name: Telephone:

Welcome to our office. Our staff is here to help you obtain the care you need in a pleasant and efficient manner. In the interest of good medical practice, it is important to establish a credit policy to avoid misunderstandings. WE WILL BILL ALL INSURANCE COMPANIES DIRECTLY if we have pertinent billing information. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE for services rendered. I authorized my insurance carrier to pay benefits directly to VANCOUVER REHABILITATION & THERAPY CLINIC, P.S. If balance becomes delinquent, I agree to pay all collection costs. Accounts over 60 days may be subject to a monthly finance charge of 18% per year of the unpaid balance, UNLESS financial arrangements have been made prior. A 50.00 bank fee will be charged for NSF checks. I authorize release of medical information to my insurance company and assign all benefits to VANCOUVER REHABILITATION & THERAPY CLINIC, P.S.

Signature of Patient or person assuming financial responsibility _____ Date: _____