



PATIENT INFORMATION FORM

Optimal Rehabilitation & Wellness

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

E-Mail: _____

Appointment Reminder ?
☐ Yes ☐ No ➔ ☐ Text ☐ Call
to What Number: _____

****PLEASE NOTE: THESE ARE AUTOMATED REMINDERS. WE ARE UNABLE TO RESPOND. IF YOU NEED TO SPEAK WITH US, PLEASE CALL THE OFFICE.**

Referring Physician: _____

Primary Care Physician: _____

EMERGENCY CONTACT

Name: _____

Number: _____ Relationship: _____

HOW DID YOU HEAR ABOUT US: _____

INSURANCE INFORMATION

Please fill in the appropriate section:

Primary Insurance: _____

Contract #: _____

Group #: _____

Secondary Insurance: _____

Contract #: _____

Group #: _____

AUTO / WORK COMP / LIABILITY CLAIM

☐ Yes ☐ No

Date of Accident: _____

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Claim #: _____

Insurance Rep.: _____

Is your claim in dispute?

☐ Yes ☐ No

SIGNATURES

Assignment and release

I, the undersigned, certify that I (or my dependent) have Insurance coverage with the above listed insurance company and assign Optimal Rehabilitation & Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all Insurance submissions.

Signature: _____ Date: _____

Acknowledgement of receipt of Notice of Privacy Practices

I, the patient or guardian, have received the Notice of Privacy Practices from Optimal Rehabilitation & Wellness.

Signature: _____ Date: _____

***** MEDICARE PATIENTS ONLY *****

I request that payment of authorized Medicare benefits made on my behalf to Optimal Rehabilitation & Wellness for services furnished to me by Optimal Rehabilitation & Wellness. I authorize any holder of medical information about me to release to the Center for Medicare Services and its Agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

***Please be aware that we have the right to discharge any non-compliant patient.**
(A non-compliant patient is any person who frequently cancels and/or does not show up for scheduled appts.)