Center for Neurorehabilitation Services

REGISTRATION FORM (PLEASE PRINT)

Today's Date:	**Chart Number (office use):**

PATIENT INFORMATION

Patient Last Name:	First:	MI	[] Mr. [] Mrs. [] Ms. [] Miss	Marital Status [] Single [] Married [] Other
Is this your legal name? If not, what is your legal name? (Former name): [] Yes [] No			Date of Birth: / /	Age: Gender [] Female [] Male
Street Address:	City:		State:	Zip Code:
Home phone:	Mobile phone:		Email:	
Occupation:	Employer Name:		Employer Phone:	
How did you hear about us (please check a box) [] Dr.			[] Friend [] Family member [] Internet [] Other	
Were you involved in an accident? [] Yes [] No			Date of the accident:	
If yes, are you represented by an Attorney? [] Yes [] No	Attorney name:		Phone :	
When did the symptoms first begin?			Was it work related? [] Yes [] No	

RESPONSIBLE PARTY (IF SOMEONE OTHER THEN THE PATIENT)

Relation to Patient: [] Spouse [] Parent [] Guardian [] Other				
First Name:	Last Name	MI	Mobile Phone:	Home Phone:
Street Address:	City:		State:	Zip:
Occupation:	Employer:		Employer Phone:	
Is this patient covered by insurance? [] Yes [] No	Is this covered by Worker's Comp? [] Yes [] No		Claim number:	

Do you have Medicare / Medicaid [] Yes [] No

Primary Insurance

Insurance Name:	Subscriber name:	Date of Birth:
Policy number:	Group number:	

Secondary Insurance

Insurance Name:	Subscriber name:	Date of Birth:
Policy number:	Group number:	

IN CASE OF EMERGENCY CONTACT:	**Relationship:**	**Phone number:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Physician. I understand that I am financially responsible for any balance, unless I am covered under workers compensation and have a signed agreement with CNS. I also authorize Center for Neurorehabilitation Services or Insurance company to release any information required to process my claims.

_____ _____

Patient Signature or Guardian Signature **Date**

PLEASE READ BEFORE SIGNING

APPOINTMENT CANCELLATIONS:

YOU MUST GIVE AT LEAST 24 HOURS NOTICE OR YOU WILL BE BILLED FOR MISSED APPOINTMENT (INSURANCE OR WORKERS COMPENSATION DOES NOT COVER MISSED APPOINTMENT)

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS

For value received, the Undersigned guarantor and/or patient (herein "the Undersigned") promises to pay the Center for Neurorehabilitation Services (herein after "Provider") all charges incurred for services rendered to the Undersigned. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s), but only as a courtesy to the Undersigned authorizes Provider to release any and all medical information necessary to complete insurance claim(s) and assigns monies due and owing under the insurance contract to said Provider. It is however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by Provider, In the event the insurance does not pay for these services. It is acknowledged that the Ultimate completing and following-up on my insurance claims is the responsibility of the Undersigned. It is further agreed by the Undersigned that in the event any monies received by the provider from the insurance carrier which are at any time after their receipt withdrawn from Provider by insurance carrier, the Undersigned will be responsible for those monies due and owing, and waives any defense for payment the Undersigned may have against the provider. In the event this account is turned over to an attorney for collection action, the Undersigned hereby agrees to pay all cost of collections, not limited to court costs but Including reasonable attorney's fees of thirty-three and one-third percent (33 1/3%) or any Sums due and payable. The Undersigned authorizes use of this form on all insurance Claims. The Undersigned further agrees to pay a finance charge for balance due over 30 days in the amount of 1.5% per month or 18% per annum. The Undersigned also gives permission to Provider to request a credit report in the event that the Undersigned defaults on payment agreements.

By signing this form, the Undersigned agrees that they have read and understood the Information. Also Undersigned understands that they are ultimately financially responsible any balance that they may generate.

_____ _____

Signature of Patient or Legal Guardian Date