vista REHAB PARTNERS

Patient Information

Last Name _____ **Middle Initial** ____ **First Name** _____

D.O.B ___ / ___ / _____ **Sex** M / F **Social Security Number** ____ - ____ - _____

Street Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Primary Phone Number (_____) _____ - _____ **Email** _____

Referring Physician (if any) _____ **Primary Physician** _____

Employment Status ___ Full Time ___ Part Time ___ Unemployed ___ Retired ___ Student

Employer Name _____

INSURANCE POLICY INFORMATION.

Do you have health insurance? Yes / No *If yes, please complete the following for your **primary insurance**.*

Policyholder's Full Name _____

Relationship _____ **Insurance Company Name (Primary)** _____

Company Phone (_____) _____ - _____ **D.O.B** ___ / ___ / _____

ID # _____ **Group #** _____

Do you have secondary insurance? Yes / No *If yes, please complete the following for your **secondary insurance**.*

Policyholder's Full Name _____

Relationship _____ **Insurance Company Name (Primary)** _____

Company Phone (_____) _____ - _____ **D.O.B** ___ / ___ / _____

ID # _____ **Group #** _____

Will you be filing a workers comp claim? Yes / No *If yes, please complete your **employer's workers comp** information below.*

Employer Name (at time of injury) _____

Date of injury ___ / ___ / _____ **Workers Comp Carrier** _____

Claim # _____ **Workers Comp Phone** (_____) _____ - _____

Claim Status ___ Open ___ Closed ___ New ___ Disputed

Will you be filing a motor vehicle accident claim? Yes / No *If yes, please complete your **policyholder and auto insurance information** below.*

Policyholder's Full Name _____

Date of injury ___ / ___ / _____ **Auto Insurance Carrier** _____

Claim # _____ **Name of Adjuster** _____

EMERGENCY CONTACT INFORMATION.

Emergency Contact's Full Name _____

Relationship _____ **Home Phone Number** (_____) _____ - _____

Cell Phone (_____) _____ - _____ **Work Phone** (_____) _____ - _____

RELEASE OF INFORMATION.

All information provided herein is true and correct. I hereby consent to treatment. I give permission to Vista Rehab Partners and its affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employers, school, related healthcare provider, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

ASSIGNMENT OF BENEFITS.

I authorize payment directly to Vista Rehab Partners and its affiliates.

PAYMENT GUARANTEE.

I agree to pay Vista Rehab Partners and its affiliates for the services provided to me or the party named above. If the law (W/C) or my payer contract prohibits my payment for these services, I will cooperate and or assist in the provision of information, releases, etc. to allow for speedy collection from my third party payor. Where the law or a payor contract does not prohibit payment by me I acknowledge responsibility for any/all account balances.

All individuals shall be accorded impartial access to treatment regardless of race, gender, national origin, disability, health status, religion, age, sexual orientation or sources of payment for care.

Patient Signature _____ **Date** _____