KEY REHAB ASSOCIATES, INC.
Patient Registration Form

Chart # / Account : ______________________ Admission Date: ____________________

PATIENT INFORMATION

Patient Name: ____

Patient's Mailing Address: ______________________________________

City: ______________________ State: __________ Zip Code: ____________

Patient's Home Phone: (   ) ____________ Cell Phone: (   ) ____________

Patient's Employer: ______________________ Work Phone: (   ) ____________

Patient's Sex: __________ Date of Birth: ___/___/___ Years of Age: _______

Patient Social Security #: ______________________________

Patient's Marital Status *(circle one)*: Single Married Widowed Divorced

Patient's Other Status *(circle one)*: Child Disabled Employed Retired Student Unemployed

PHYSICIANS

Referring Physician: ____________________ Primary Physician: ____________________

GUARANTOR (Person Responsible For Payment if Other Than Patient)

Guarantor Name: ____

Guarantor's Mailing Address: ____________________________________

City: ______________________ State: __________ Zip Code: ____________

Guarantor's Home Phone: (   ) ____________ Cell Phone: (   ) ____________

Guarantor's Employer: ______________________ Work Phone: (   ) ____________

Guarantor's Sex: __________ Date of Birth: ___/___/___ Years of Age: _______

Guarantor's Social Security #: ______________________________

Guarantor's Marital Status *(circle one)*: Single Married Widowed Divorced

Guarantor's Other Status *(circle one)*: Disabled Employed Retired Student Unemployed

Guarantor's Relation to Patient *(circle one)*: Husband Wife Mother Father Employer Other

EMERGENCY CONTACT

Note: *The phone # for this person CANNOT be the same as the patient or guarantor's phone number(s).*

Name of Person to Contact in Case of Emergency: ______________________________

Contact's Home Phone: (   ) ____________ Work Phone: (   ) ____________

Emergency Contact's Relationship to Patient: ______________________

Patient Name: ______________________________ **Chart #:** __________

INSURANCE INFORMATION

(Please write clearly and complete all blanks in relevant sections below)

PRIMARY HEALTHCARE INSURANCE:

Company Name: ______________________________
Mailing Address: ______________________________
City: ______________ State: ________ Zip: __________ Phone #: ( ) __________
Name of Insured: ______________ Insured Birth Date: __________ Relationship: ________
Social Security #: ______________ Policy #: ______________ Group #: __________

SECONDARY HEALTHCARE INSURANCE, IF ANY:

Company Name: ______________________________
Mailing Address: ______________________________
City: ______________ State: ________ Zip: __________ Phone #: ( ) __________
Name of Insured: ______________ Insured Birth Date: __________ Relationship: ________
Social Security #: ______________ Policy #: ______________ Group #: __________

IF AUTO ACCIDENT, PROVIDE BOTH HEALTH INSURANCE ABOVE & AUTO INSURANCE BELOW:

Date of Accident: ____/____/____
YOUR Auto Insurance Company Name (regardless of party at fault): ______________
Phone #: ( ) ______________ Name of Contact There: ______________
Mailing Address: ______________________________
City: ______________ State: __________ Zip: __________
Name of Insured: ______________ Insured Birth Date: __________ Relationship: ________
Social Security #: ______________ Policy #: ______________ Group #: __________
Name of Attorney, if any: ______________ Attorney Phone #: ( ) __________

IF WORKER'S COMP ACCIDENT, PROVIDE EMPLOYER INFORMATION BELOW:

Date of Accident: ____/____/____ Employer Name: ______________
Phone #: ( ) ______________ Name of Contact There: ______________
Mailing Address: ______________________________
City: ______________ State: __________ Zip: __________
Employee Name: ______________ Employee Birth Date: __________
Social Security #: ______________ Claim #, if known: ______________

IF LIABILITY ACCIDENT, PROVIDE INFORMATION BELOW:

Date of Accident: ____/____/____ Name of Person/Company Liable for your Injury: ______________
Phone #: ( ) ______________ Name of Contact There: ______________
Mailing Address: ______________________________
City: ______________ State: __________ Zip: __________
Name of Attorney, if any: ______________ Attorney Phone #: ( ) __________

Key Rehab Associates, Inc.

Patient's Name:______________________________ Medical Record #__________

Acknowledgment of Services Rendered

I understand that by accepting services from Key Rehab Associates, Inc., I,________________________, am incurring a legal obligation to pay for said services. It is understood that I am financially responsible to Key Rehab Associates, Inc. for any and all charges not paid by third party payer.

Assignment of Insurance Benefits

In consideration of the services received or to be received, I hereby assign Key Rehab Associates, Inc. any third party payment due to me or that may become due to me under any and all insurance policies held by me or for my benefit for services rendered in the course of this admission or a related admission. I hereby authorize and direct that all insurance benefit payments be made directly to Key Rehab Associates, Inc.. I recognize that if payment is made directly to me by any insurance company, the amount received up to the amount of billed charges for services rendered is the property of Key Rehab Associates, Inc. I understand and acknowledge that I am financially responsible to Key Rehab Associates, Inc. for any and all charges not paid by this assignment. A copy of this assignment shall be valid as the original.

Release of Information

I authorize and agree to the release of general information concerning this admission and my condition to any party/insurer properly authorized to request and receive such information. The undersigned agrees to allow Key Rehab Associates, Inc. access to medical records which will be stored at designed locations. I have received information regarding the release of information policy /requirements. I am aware and agree to my therapist(s) periodically providing my referring physician with a verbal or written progress report.

Medical Assignment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on MY behalf. I agree to the services being provided and assign the benefits payable for therapy services to the organization furnishing the services or authorize such organization to submit to Medicare for payments to me.

Bill of Rights

I have received a copy of the Patient's Bill of Right of Key Rehab Associates, Inc.

Privacy Notice

I have received or have been offered and have refused a copy of the Privacy Notice enacted by Key Rehab Associates, Inc. in accordance with the federal guidelines of the Health Information Portability and Accountability Act.

Consent for Treatment

I agree to treatment by a registered therapist, as prescribed by my physician. The therapist has explained to me to my satisfaction why I need therapy, how long I should need therapy and the procedures to be used.

____
Patient's Signature

____
Patient Representative's Signature & Relationship

____
Date of Signature

____
Insured's Signature -if different from patient

____
Signature of Witness

****If patient is unable to sign, please state reason:

APPOINTMENT REMINDER PERMISSION

I, ______________________________________, grant my permission for Key Rehab Associates, Inc., to call, e-mail and/or send me a text message prior to an appointment to remind me of the appointment date and time. For voice calls, I understand that a message may be left regarding my appointment at the number provided below.

I would prefer to be reminded of my scheduled appointments by:

(Check which ones you grant permission for us to use and provide information)

___ VOICE Phone Number: ______________________________
___ TEXT Mobile Number: ______________________________
___ EMAIL Email Address: ______________________________

I understand that I can request that these reminders stop at any time, and that standard rates may apply to all text messages.

Patient Name: ______________________________

Patient Signature: ______________________________

Parent/Guardian Name: ______________________________

Parent/Guardian Signature: ______________________________

Date: ______________________________

Witness: ______________________________