Physical Rehabilitation Group, LLC

Patient Information

Please check claim type:

( ) Workers Compensation ( ) Health Insurance ( ) Self Pay ( ) Personal Injury/Attorney

( ) Automobile Injury ( ) Other ________ ( ) Date of Injury ________

Patient Information:

Full Name: ____________________ ( ) male ( ) female

Mailing Address ____________________

City: ____________ State: ________ Zip: ________

Email Address: ____________________

Phone (H): ________(W): ________ (C):________Marital Status: ________

SS#: ____________ Date of birth: ____________

In case of emergency, contact:________Relationship: ________Phone: ________

How did you hear about us? ____________________

Has a claim been filed to a workers compensation carrier? ( ) yes ( ) no

If so, contact person: ____________Phone: ____________

Primary insurance: ____________________

Policy #: ____________ Group #: ____________

Policy holder's name: ____________Date of birth: ____________

What is your relationship to policyholder? ( ) self ( ) spouse ( ) child ( ) other

Secondary insurance: ____________________

Policy #: ____________ Group #: ____________

Policy holder's name: ____________Date of birth: ____________

What is your relationship to policyholder? ( ) self ( ) spouse ( ) child ( ) other

By my signature below, I hereby authorize the release of medical information needed to process my claim through my insurance company. I authorize my insurance benefits to be paid directly to Physical Rehabilitation Group and agree that I am financially responsible for any amounts not covered and/or paid by them. It is the policy of this office to collect charges for services as they are rendered, unless prior arrangements are made and credit is established. Insurance patients are responsible for paying their co-payments and deductible at the time services are rendered. I hereby authorize such treatment as is necessary and to perform medical treatment based on findings during said treatment. I hereby certify that I have read and fully understand the above authorization for treatment, the reason the above-named treatment is considered necessary the advantages and possible complications, if any, as well as viable alternative modes of treatment which were explained to me. I also certify that no guarantee or assurance had been made as to the results that may be obtained.

Signed: ____________________ Date: ____________

Responsible party signature (if different from above): ____________________

Corporate Office – P.O. Box 3408, Irmo, SC 29063 (P) 803-732-5887 (F) 803-732-5997