A.R.I.
ADVANTAGE REHAB INC.

New Patient Registration Form

Name: Please print legibly

First Name:_____MI_____

Last Name:_____

Date of Birth:_____/_____/_____

☐ Male ☐ Female Emergency Contact:_____

Phone number:_____

Primary Phone: (_____)_____

Secondary Ph: (_____) _____

Home Address:

_____

City:_____ State:_____

Zip Code: _____

SS# _____

(SS# **MUST** be filled in if you are **VA or Medicare**)

If you are Medicare have you had any PT so far this calendar year? ☐ **YES** ☐ **NO**

Email Address: (used for ARI's educational blog and updates)

_____

Insurance Information

Primary Insurance:

_____

Secondary Insurance:

_____

Person responsible for the account:

_____

Date of Birth of responsible party:_____

Address if different from patient:

_____

City:_____ State:_____

Zip Code:_____

If this is a *work comp claim* the following information must be provided for billing

Place of Employment:

_____

Address of Employment:

_____

City:_____State:_____Zip:_____

Phone number of Employer:

_____

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above. I assign directly to Advantage Rehab Inc 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 for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____/_____/_____

Responsible Party's signature Today's Date