CENTRAL NEBRASKA
Rehabilitation Services

Date:

PATIENT INFORMATION

Patient Name	Last:	First:	Middle:
Preferred Name:	SSN:	Birth Date:	Gender: M / F
Maiden or Other Name:		Marital Status: Married / Single / Divorced / Widowed	
Mailing address:			
City:		State:	ZIP Code:
Email:		Preferred Phone:	
Alternate Phone:			
Emergency Contact Name:		***Phone:***	
Guarantor Name (if patient is UNDER 18):		***Relationship to Patient:***	
Address:			
City:		State:	ZIP Code:
SSN:		Birth Date:	Phone:

EMPLOYMENT INFORMATION

Current employer:	
Phone:	

REASON FOR VISIT

What area are we treating today (ex. back, knee, elbow, etc):	
Referring Doctor:	
Date symptoms began?	
Accident related: Y / N	If yes, Work Related Accident? Y / N
Auto accident: Y / N If yes, date of accident:	If yes, what state?
Injured in home: Y / N	
Date of Surgery, if applicable?	
Are you currently receiving Home Health Services? Y / N	

INSURANCE INFORMATION

Primary Insurance Carrier:		
Policyholder Name:		Birth Date:
Policyholder SSN:	Relationship to Patient:	
Secondary Insurance Carrier:		
Policyholder Name:		Birth Date:
Policyholder SSN:	Relationship to Patient:	

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Other Insurance:

Visit Limits:

Your insurance may have a calendar year limit as to how many therapy visits they will allow, this may also include any chiropractor visits or osteopathic physiotherapy visits….although as a courtesy we track the visits you have here, we cannot track any treatment outside our facility. You may be responsible for any visits that go over your covered limit. Initial _____

Have you had any Speech, Occupational, or Physical Therapy this year? Y / N Any Chiropractic visits this year? Y / N

At which facility?

If Medicare:

Are you covered by spouse's employment? Y / N	Are you also covered by a Group Health Plan? Y / N
Do you receive Black Lung Benefits? Y / N	Are you receiving Work Comp Benefits? Y / N

AUTHORIZATION (Assignment of benefits/financial agreement):
I hereby give lifetime authorization for payment of insurance benefits to be made directly to Central Nebraska Rehabilitation Services, LLC, for services rendered here. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize Central Nebraska Rehabilitation Services, L.L.C., to release all information to insurance companies, attorney, or other physicians to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original. I understand that a 1% finance charge will be imposed on each item of my account, which has not been paid within ninety (90) days from my last date of service at Central Nebraska Rehabilitation Services, LLC. I understand that this finance charge will be computed by applying the periodic rate (1%) per month or and ANNUAL PERCENTAGE RATE of twelve percent (12%). This is applied to the "overdue balance" of my account. The "overdue balance" of my account is calculated by taking the balance owed ninety (90) days after last date of service, and then subtracting any payments or credits applied to my account during this time. I also understand that there is a $25.00 charge on all checks that are returned from the bank.

I also understand the minimum payment requirement on any balances due is 5% of the total balance or $50, whichever is greater.

HIPPA PRIVACY NOTICE:
The signature below acknowledges I was offered a copy of Central Nebraska Rehabilitation Services L.L.C. notice of privacy practices.

Permission to release medical information to: _____ (optional)

CONSENT OF MEDICAL TREATMENT:
Knowing that I have (or the patient listed above has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic procedures and to such medical treatment rendered by Central Nebraska Rehabilitation Services L.L.C.

SUPPLIES:
I understand that if my health insurance carrier does not cover a supply, I am responsible for payment in full for the supply.

NOTES:

Signature of patient	Date