Atlas Rehabilitation

PATIENT INFORMATION

Last Name:____________________ First Name: ____________________________ MI: _________

Mailing Address: ____

City, State, Zip: ____

Home Phone: ____________________________ Alternate Phone: ____________________________

Sex: M ____ F _____ Social Security Number: ____

Date of Birth: ___ / ___ / _____ Age: _______________

RESPONSIBLE PARTY / POWER OF ATTORNY INFORMATION

Last Name:________________________ First Name: ____________________________ MI: _______

Mailing Address: ____

City, State, Zip: ____

Home Phone: ____________________________ Alternate Phone: ____________________________

Check all that apply: ___ Power of Attorney ___Heath Care Surrogate

___Responsible Party ___Court Appointed Guardian

INSURANCE INFORMATION

Medicare # ____________________Effective Date:_________ Medicaid # ____________________

Name of insurance: _____________________________ Group #: _____________________________

Insurance ID #: _____________________________ Group Name:_____________________________

Mailing Address: ____ Phone #: ___________________

By signing below you acknowledge that all the above stated information is true and correct.

Signature: ____ Date: ______________________

Printed Name: ____ Relationship:_________________________

Notice of Privacy Policy Acknowledgment

I understand under the Health Insurance Portability and Accountability Act (HIPAA) that I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can be used to:

- Conduct, plan, and direct my treatment and care
- Follow up among multiple healthcare providers who are also involved either directly or indirectly in my care and treatment.
- Obtain payment from third party providers.
- Conduct normal healthcare operations such as quality assessment and physician / physical therapy certifications.

I understand that my PHI will not be released to anyone else other than the above stated without my consent. However, I consent to the release of my PHI to the below stated individuals / practices or institutions. You make revoke this consent at any time.

Name:____ Relationship: __________________________
Name:____ Relationship: __________________________
Name:____ Relationship: __________________________

Please explain any PHI that you do not wish to have disclosed to the above stated:
____
____
____
____
____

I have received a copy of the Notice Of Privacy Practice:

Signature of patient / representative: ____

Printed Name: ____ Date: ______________

Authorization for Treatment

I authorize Atlas Rehabilitation, LLC to process and bill my insurance for all medical care / treatments provided. I understand that in order to bill my care, certain medical information will be released to my insurer. I understand that I will be responsible for any copay, deductible or any treatment provided that is not covered by my insurance. I also authorize any licensed employee (PT, OT, ST) of Atlas Rehabilitation to treat me at my home.

Signature of patient / representative: ____

Printed Name: ____ Date: ________________