

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Phone (home) _____ (work/cell) _____ Social Security # _____

Employer's Name & Address _____

Emergency Contact _____ Phone _____

Referring Physician _____ Primary Care Physician _____

Would you like to receive NRSMA related information from us by e-mail? ____ yes ____ no
If yes, please provide e-mail address: _____

<p align="center">Workers' Compensation Claims</p> <p>Date of injury _____ Claim# _____</p> <p>Please send claims to: _____ _____ _____</p> <p>Attn: _____ Phone#: _____</p>

<p align="center">Auto Insurance Claims</p> <p>Name of Insured _____ Policy#: _____ Claim #: _____ Insurance Co. _____ Address _____ City/State/Zip _____ Phone # _____</p> <p align="center">If your insurance company requires a special form please provide this to us. Thank You.</p>
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Assignment of Benefits and Release of Information

I hereby authorize Northern Rehabilitation & Sports Medicine Associates, Inc. to obtain or release all requested health information regarding care and treatment of myself or my dependents from/to insurance companies/workers comp insurance/employer and above-mentioned medical professionals. I also authorize payment to the above-named physical therapy clinic of the medical plan otherwise payable to me.

I understand and agree that regardless of insurance status, I am ultimately financially responsible for full payment of services rendered to me or my dependents in this office. In addition, any unpaid balance after 90 days will be subject to interest charges of 1½% per month or a minimum of \$2.50 per month.

Signature _____ Date _____

I also authorize release of above mentioned information and payment to my secondary insurance company.

Signature _____ Date _____

To All Medicare Patients

According to new Medicare rules, all patients seen in an independent out-patient clinic must be seen by their referring physician every 30 days. Any claims sent for services not in that time frame may be denied.

