

Patient Summary Information

Patient

Admission Date		Account #		Therapist	
Name			Gender		DOB
Address			City		State
Zip	Home Phone		Mobile Phone		Work Phone
E-mail Address				SS#	
Marital Status		Employment Status		Employer Name	

Emergency Contact

Name			Relation		
Home Phone		Mobile Phone		Work Phone	

Guarantor/Responsible Party

Name			Relation		
Address			City		State
Zip	Home Phone		Mobile Phone		Work Phone

Insurance/Authorization

Carrier(s)		Policy		Group	
Insured Name		DOB	Relation		Copay

Injury/Illness

Onset Date		Surgery Date		Referral	
Diagnosis			Dx Code		Phone
Employment Related	Auto Related	Other Accident	W/C Claim	Post Op	

HIPAA

<p>I acknowledge that I have been provided with a copy of the R&F Inc. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by R&F, Inc. and its legal DBAs along with my rights with respect to my health information.</p>	
<p>_____</p> <p>Initial</p>	

Other Information

Have you had therapy this year? <input type="checkbox"/> Yes <input type="checkbox"/> No		Area of Tx		Where/When	
Have you had home health care in the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of last Tx	
Home Health Care Provider					

R & F, Inc. will complete and submit insurance claims for you. However, the patient/guardian has agreed to accept full financial responsibility for services regardless of insurance. By signing here, you are authorizing Assignment of Insurance Benefits to R & F Inc. You have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 and Corporate Payment Policy. Your signature authorizes R & F, Inc. and its legal DBA's to administer all treatments, including changes, deemed medically necessary by your Therapist and referring physician.

_____ (Signature) _____ (Date)

If patient has Medicare, complete Medicare Secondary Payor Questionnaire as required by law.