Patient Registration Packet

If you are accessing this form online, print the form. Complete all pages; signature is REQUIRED on pages 2, 3, 4, 5 and 7.	Today's Date:

1. Patient information:

Last Name:		First Name: (Legal)		M.I.:	
Address:					
City:		State:		Zip Code:	
Phone (Home):		Phone (Work):			
Phone (Cell):		Email address:			
Social Security#:		Birthdate:		Gender:	Male Female (circle one)
Marital Status:	Married Single Divorced Widowed (circle one)	Spouse's Name: (if applicable)			
Employer's Name:		Occupation:			
Employer's Address:		Employer's Phone:			
City:		State:		Zip Code:	

2. Please complete below if patient is a minor:

Last Name of Mother/ Legal Guardian :		First Name: (Legal)		M.I.:	
Address:					
City:		State:		Zip Code:	
Phone (Work):		Phone (Cell):			
Social Security#:		Birthdate:			
Employer's Name:		Occupation:			
Employer's Address:		Employer's Phone:			
City:		State:		Zip Code:	

Last Name of Father/ Legal Guardian :		First Name: (Legal)		M.I.:	
Address:					
City:		State:		Zip Code:	
Phone (Work):		Phone (Cell):			
Social Security#:		Birthdate:			
Employer's Name:		Occupation:			
Employer's Address:		Employer's Phone:			
City:		State:		Zip Code:	

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4. Primary care physician information:

Name:		Phone:			
Address:					
City:		State:		Zip Code:	

5. How were you referred to this office?:

Physician Family Friend Emergency Room Yellow Pages Other (circle one)	
Name:	

6. Insurance information:

Primary Insurance Company Name:			Insurance Type:	PPO HMO POS Other (circle one)	
Address:					
City:		State:		Zip Code:	
ID #:		Group #:		Effective Date:	
Insured's Name:		Relation to Patient:			
Social Security#:		Birthdate:			
Employer's Name:		Marital Status:	Married Single Divorced Widowed (circle one)		

Secondary Insurance Company Name:			Insurance Type:	PPO HMO POS Other (circle one)	
Address:					
City:		State:		Zip Code:	
ID #:		Group #:		Effective Date:	
Insured's Name:		Relation to Patient:			
Social Security#:		Birthdate:			
Employer's Name:		Marital Status:	Married Single Divorced Widowed (circle one)		

THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE:

Name of person completing this form: ____

Signature of person completing this form: _____________________________________

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Health Care Consent

Patient Name: _______________________________ **Date of Birth**: _________________

CONSENT TO TREAT: I, for myself (or the patient named above), hereby consent to such medical treatment and diagnostic procedures as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider, ask questions regarding such treatment options and understand the options discussed.

PERSONAL BELONGINGS: I assume full responsibility for all items of personal property that I have brought to Crown City Rehabilitation and hereby release Crown City Rehabilitation of all liability in the event of loss or damage to such property.

Signatue of Patient: _______________________________________ Date: _____________

Signature of Authorized Representative: _______________________ Date: _____________

Name of Authorized Representative: _____________________ Relationship: ___________

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Notice Of Privacy Practices Acknowledgement

Patient Name: ________________________________ **Date of Birth**: _________________

The Notice of Privacy Practice (NPP) tells you how we may use and share your health records. It also describes your rights with respect to your health records. **Please read it.**

- We will use and share your health records to treat and bill you for services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

I understand that the NPP is available on the Crown City Rehabilitation, website (Crown City Rehabilitation) and at my physician's office.

I acknowledge receipt of the Empire Specialists Notice of Privacy Practices (NPP).

Signatue of Patient: _______________________________________ Date: _____________

Signature of Authorized Representative: ______________________ Date: _____________

Name of Authorized Representative: _____________________ Relationship: ___________

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Phone Message and Contact Authorization

Patient Name: _________________________________ **Date of Birth**: __________________

Please CHECK the appropriate answer below:

Do the physicians and staff of Crown City Rehabilitation have your permission to leave messages containing medical and/or financial information on your **answering machine**?

At home ________ Yes ________ No *

At work ________ Yes ________ No *

* IF YOU CHECK "NO", ONLY THE DATE, THE TIME AND LOCATION OF APPOINTMENTS WILL BE LEFT ON YOUR ANSWERING MACHINE.

Please complete below: **I give authorization to the doctors and staff of Crown City Rehabilitation to discuss my medical and/or financial information with the following people:**

Name	Relationship	Phone

Signatue of Patient: ____ Date: ______________

Signature of Authorized Representative: _______________________ Date: ______________

Name of Authorized Representative: ______________________ Relationship: ____________

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Acknowledgement of Receipt of Crown City Rehabilitation Financial Policy Summary

Patient Name: _______________________________ **Date of Birth**: _________________

Crown City Rehabilitation
FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to the successful treatment of your medical condition. Please understand that payment is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at 847-352-5511.

The patient, or legal guardian, is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient or guarantor for patient, agree to pay Empire Specialists for all services and supplies provided to you (or the patient, as applicable) at the established rates, including any deductibles, co-payment or other charges, as permitted by third party payors. By signing this financial policy summary, you accept responsibility for any costs, including attorney's fees incurred by Crown City Rehabilitation in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of your knowledge, complete and accurate.

Additionally:

Full payment is due at the time of service for self-pay patients or if insurance information (and copy of insurance card) has NOT been provided.

We accept cash, check or credit card (Visa, Master Card, Discover and American Express).

All patients must complete our "patient registration packet" and other forms provided at the time of registration.

For cases in which we bill insurance directly, we MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD.

Please notify us immediately of any changes in your insurance information or coverage.

At least 24 hours' notice is required for copies of medical records or x-rays and there may be a nominal fee.

You are ultimately responsible for payment of all services.

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Acknowledgement of Receipt of Crown City Rehabilitation Financial Policy Summary (Continued)

Medicare:

We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays, your deductible and charges for any services not covered by Medicare. If you have supplemental insurance, we will bill it directly for you. You will receive a bill after your insurance has paid.

HMO/PPO:

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. We are a member of most, but not all, insurance plans. You are responsible for verifying that we are an in-network provider under your plan. All patients will be responsible for their co-payments, co-insurance and deductibles, as well as any services not covered by your insurance or deemed by your insurance as not medically necessary.

If there is a dispute regarding the payment of your insurance claim, CC has the right to bill you prior to the resolution of that dispute and to anticipate payment from you.

Auto and Other Personal Injury Claims:

If you are here a s a result of an accident claim, we may require you to be a self-pay patient, or we may require information regarding both health insurance and accident/auto insurance.

I understand that if the office agrees to bill insurance as a courtesy to me, I must submit information as needed to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

Signatue of Patient: ____ Date: _____________

Signature of Authorized Representative: _______________________ Date: _____________

Name of Authorized Representative: ______________________ Relationship: ___________