Rehabilitation Associates of Riverdale Medicine

Registration Form Today's Date____/____/20____

LAST NAME_____ FIRST NAME_____ ☐ M ☐ F

ADDRESS_____ CITY_____ STATE____ ZIP_____

HOME TELEPHONE (_____) _____-_____ WORK TELEPHONE (_____) _____-_____

MOBILE PHONE (_____) _____-_____ EMAIL ADDRESS_____

DATE OF BIRTH ____/____/_____ AGE_____ SOCIAL SECURITY NUMBER _____/_____/_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW (ER) LIVE: ☐ ALONE ☐ WITH:_____

NEXT OF KIN _____ RELATIONSHIP_____ TELEPHONE_____

NUMBER OF STAIRS INSIDE _____ NUMBER OF STAIRS OUTSIDE _____

EMPLOYER NAME_____ OCCUPATION _____

EMPLOYER ADDRESS_____ EMPLOYER TELEPHONE_____

REFERRED BY:_____

REFERRING PHYSICIAN_____ TELEPHONE_____

PRIMARY CARE PHYSICIAN _____ TELEPHONE_____

SOCIAL HISTORY:

PACKS OF CIGARETTES/DAY:____ USE OF RECREATIONAL DRUGS: ☐ Y ☐ N # OF ALCOHOLIC DRINKS PER WEEK:_____

PAST MEDICAL HISTORY:

☐ KIDNEY DISEASE ☐ LUNG DISEASE ☐ ASTHMA ☐ ULCERS
☐ HEARTBURN ☐ HEART DISEASE ☐ DIABETES ☐ CANCER ☐ OTHER_____

SURGERIES (DATES):_____

CURRENT MEDICATIONS:_____

ALLERGIES TO MEDICATIONS:_____

☐ RIGHT-HANDED ☐ LEFT-HANDED HEIGHT_____ WEIGHT_____ Any change over the past 6 months?_____

PHYSICAL DEMANDS at:

WORK_____ EXERCISE_____ SPORTS_____

HOBBIES_____ OTHER_____

FAMILY HISTORY: are there any immediate family members with the following:

☐ neurological disorder ☐ heart disease ☐ back problems ☐ neck problems ☐ cancer ☐ diabetes ☐ joint problems

Details:_____

ASSIGNMENT OF BENEFITS (MEDICARE/PRIVATE PATIENTS):

I authorize payment of medical benefits directly to Rehabilitation Associates of Riverdale Medicine for services described. I accept full responsibility for the total amount of bill.

Signature_____Date____/_____/_____

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or their intermediaries or carriers or to the billing agent of this physician, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature_____Date____/_____/_____

Private Insurance: if provided with your insurance information and a copy of your insurance card we will process the claim for you and provide all the necessary paperwork to accompany your claim. If your insurance company is slow to pay or denies the claim, it is your responsibility to follow-up with them. **However, you are responsible for your copayment and any deductible at the time of service and/or any remaining balance not covered by your insurance.**

Medicare: we will submit your claim to Medicare. We accept Medicare assignment, therefore payment will come directly to us. However you are still responsible for the 20% co-pay of what Medicare approves. If you have a secondary insurer, please be sure to provide us with a copy of your insurance card so we can submit to your secondary carrier.

No-fault Insurance: if your claim was verified prior to your appointment, we will submit the bill to your insurance carrier in lieu of payment at the time of service. We expect you to promptly complete and mail to your insurance carrier your PIP form and any other necessary paperwork needed by the carrier to process your claim. **You will be responsible for any deductible and copayment.** If you have a secondary insurer to cover this balance, it is up to you to file the claim.

Workers Compensation: if you are being seen due to a work-related injury, we will file with your compensation carrier. We expect you to provide us with the complete information to properly process your claim. If the insurance carrier denies the claim, you are responsible for the outstanding balance.

Signature_____Date____/_____/_____

Patient acknowledgment of receipt of notice of privacy practices for protected health information from Riverdale Medicine

DATE _____/_____/_____ PATIENT'S NAME (printed)_____

SIGNATURE OF PATIENT OR REPRESENTATIVE_____

Name Of Representative (if applicable)_____ relationship to patient_____