

REHABILITATION RESOURCES OF MARYLAND, Inc.

PATIENT INFORMATION

NAME _____
ADDRESS _____

PHONE H) _____
W) _____
Cell) _____
E-mail) _____
S.S.# _____ M / F
DOB _____ AGE _____
EMPLOYER _____

DIAGNOSIS / PROBLEM _____

DATE OF INJURY / SURGERY _____

REFERRING PHYSICIAN

ADDRESS _____

PHONE _____

PRIMARY CARE PHYSICIAN

ADDRESS _____

PHONE _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

ADDRESS _____

PHONE H) _____
W) _____

How did you find out about us? _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO.

ADDRESS _____

PHONE _____
NAME OF INSURED _____
RELATIONSHIP _____
POLICY# _____ GRP# _____
EMPLOYER _____

SECONDARY INSURANCE CO.

ADDRESS _____

PHONE _____
NAME OF INSURED _____
RELATIONSHIP _____
POLICY # _____ GRP# _____
EMPLOYER _____

EMPLOYMENT RELATED Y / N

EMPLOYER _____
WORKERS COMP CARRIER _____
ADDRESS _____

PHONE _____ CLM# _____
ADJUSTOR / CASE MGR. _____

AUTO ACCIDENT Y / N

See automobile supplemental information sheet

I agree to receive (or give permission for my above named child to receive) Physical and/or Occupational Therapy services appropriate for this condition. I authorize release of any information that may assist in care and to process insurance claims. I have received the Notice of Patient Information Practices, and I understand that unless I provide written permission to do otherwise, my personal health information will be used for the purposes listed on that form only. I also authorize direct payments to be made to Rehabilitation Resources of Maryland, Inc. for billed services and I understand that I am responsible for any amount not covered by my insurance company.

SIGNATURE _____ (SEAL) DATE _____
WITNESS _____ DATE _____

HUNT VALLEY PHYSICAL THERAPY & REHABILITATION

11350 McCormick Road, Suite LL8 • Hunt Valley, MD 21031 • (410) 527-1794 • Fax (410) 527-9467
www.huntvalleypt.com

JACKSONVILLE PHYSICAL THERAPY

14307 Jarrettsville Pike • PO Box 186 • Phoenix, MD 21131 • (410) 628-7011 • Fax (410) 628-2305
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