REGISTRATION
(PLEASE PRINT)

PROFESSIONAL REHAI TATION SPECIALISTS, P.A.
380 Limit Street
Leavenworth, KS 66048

PATIENT INFORMATION

Name ______________________________ Soc. Sec. # ____________
Last Name First Name Initial

Address ______________________________ Home Phone # ____________

City ____________ State ______ Zip ______ Date ______

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By ______________________________ Occupation ____________

Business Address ______________________________ Business Phone # ____________

Referring Physician ______________________________ Phone # ____________

Physicians Address ______________________________

Is Condition Related To Auto Accident? ☐ Yes ☐ No What State? ______ **Date Of Onset Of Pain Or Accident** ______

In Case Of Emergency Who Should Be Notified? ______________________________ Phone # ____________

Do You Have Or Have You Ever Had Cancer? ☐ Yes ☐ No

PRIMARY INSURANCE

Person Responsible For Account ______________________________
Last Name First Name Initial

Relation To Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (If Different From Patient's) ______________________________

City ____________ State ______ Zip ______ Phone # ____________

Insurance Company ______________________________ ID # ____________

ADDITIONAL INSURANCE

Is Patient Covered By Additional Insurance? ☐ Yes ☐ No

Insurance Company ______________________________ ID # ____________

FINANCIAL POLICY

YOUR CO-PAY WILL BE DUE AT EACH VISIT TO OUR OFFICE. AS A SERVICE TO YOU, we will file a maximum of (2) insurances. Any additional filing is the responsibility of the patient. The portion not paid by your insurance is the responsibility of the patient. If payment has not been received from your insurance within 90 days after we file, the entire balance will then be due and payable by you.
WE ACCEPT CASH, CHECK, VISA AND MASTERCARD AS PAYMENT FOR OUR SERVICES. If you need to establish a payment plan do this with the insurance coordinator during the first visit to our office, not after your bill is overdue. A statement, showing the amount you owe, will be sent to you after your insurance has assigned contractual discount and paid its portion. Accounts showing no payment (30) days after a statement is sent will accrue a finance charge of 1.5% per month. Accounts showing no payment or an approved payment plan after (60) days will immediately be turned over to our collection agency. At this point, the patient will become responsible for any and all collection/attorney fees. If there are potential financial situations, which causes your medical expenses to be currently difficult to handle, please let our billing staff help you work out a payment plan prior to the beginning of the legally required collections process.

ASSIGNMENT AND RELEASE (HIPPA)

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________
Name Of Insurance Company(ies)

and assign directly to Professional Rehabilitation Specialists, P.A. (PRS) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges or portion of charges whether or not paid by insurance. I give consent to PRS for use and disclosure of all protected health information to carry out treatment, insurance filing, payment, collections and healthcare operations.

______________________________ ______________ ______________
Responsible Party Signature Relationship Date