Quality Care Rehabilitation Professionals
42536 Hayes Road, Suite 100, Clinton Township, MI 48038
(586) 286-9644 | Fax: (586) 286-9647 | www.qcrp.com

Patient Information

Patient Name _____ _____ _____ _____
First *Last* *MI* Today's Date

Address _____ _____ _____ _____
Street *City* *State* *Zip*

Birthdate _____ **Age** _____ **Social Security #** _____ - _____ - _____

Marital Status Married Single Widowed Divorced Separated

Home Phone (_____) _____ **Work Phone** (_____) _____

Cell Phone (_____) _____ **Other Phone** (_____) _____

Family Physician _____ **Referring Physician** _____

Employer _____ **Occupation** _____

Employer Address _____ _____ _____ _____
Street *City* *State* *Zip*

Emergency Contact _____ **Relationship** _____

Home Phone (_____) _____ **Other Phone** (_____) _____

How did you hear about us? _____

Complete this section if someone OTHER THAN THE PATIENT is financially responsible

Name _____ _____ _____
First *Last* *MI*

Address _____ _____ _____ _____
Street *City* *State* *Zip*

Birthday _____ **Age** _____ **Social Security #** _____ - _____ - _____

Occupation _____

Home Phone (_____) _____ **Work Phone** (_____) _____

Cell Phone (_____) _____ **Employer** _____

Employer Address _____ _____ _____ _____
Street *City* *State* *Zip*

INSURANCE INFORMATION

If covered by Medicare, what is your card number? _____

Primary Insurance **Name of Insurance Company**: _____

Address _____ _____ _____ _____
Street *City* *State* *Zip*

Insured's Name _____ _____ _____
First *Last* *MI*

Birthday _____ **Age** _____ **Social Security #** _____ - _____ - _____

Employer for card _____ **Relationship to Cardholder** _____

Group Number _____ **Policy ID Number**

Secondary Insurance **Name of Insurance Company**: _____

Address _____ _____ _____ _____
Street *City* *State* *Zip*

Insured's Name _____ _____ _____
First *Last* *MI*

Birthdate _____ **Age** _____ **Social Security #** _____ - _____ - _____

Employer for card _____ **Relationship to Cardholder** _____

Group Number _____ **Policy ID Number** _____

WORKMAN'S COMPENSATION & AUTO INSURANCE CLAIMS

IS THIS A WORKMANS COMPENSATION CLAIM? Yes / No Date of Injury _____

IS THIS RELATED TO AN INJURY FROM AN AUTO ACCIDENT? Yes / No Date of Injury _____

IS THIS VISIT FOR AN INJURY WITH A PENDING LEGAL CLAIM Yes / No Date of Injury _____

IF YOU ANSWERED YES TO ANY OF THE PREVIOUS THREE QUESTIONS PLEASE FILL OUT THE FOLLOWING INFORMATION

Place of Injury or Accident:

Address _____ _____ _____ _____
Street *City* *State* *Zip*

Insurance Name of Insurance Company: _____

Address _____ _____ _____ _____
Street *City* *State* *Zip*

Adjusters Name _____ _____ _____
First *Last* *MI*

Adjusters Phone (_____) _____ **Claim Number** _____

We must have proper authorization for treatment of workman's comp, auto accidents and HMO insurances. Without this, the charges and thus the payment for treatment will be the patient's responsibility. Please help us to avoid any unnecessary out of pocket expenses. Out office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered services amounts.

Please read and then sign the following:

I herby assign, transfer and set over to Quality Care Rehabilitation Professionals, Inc. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits and process ANY CLAIM. This authorization shall remain valid until written notice is given by me revoking it. I understand that I am responsible for all charges whether or not they are covered by insurance.

Signature _____ **Date** _____