

DAKOTA REHABILITATION CENTER PATIENT REGISTRATION FORM

Name _____ **Date of Birth** _____ **Male / Female**

Address _____

City _____ **State** _____ **Zip** _____

Home Phone# _____ **Work Phone#** _____

Cell Phone# _____ **Social Security Number** _____

Marital Status (circle one): **Single Married Widow Divorced Other**

Date of Injury/Accident _____ **Allergies** _____

If motor vehicle accident, in which state did the accident occur? _____

Employer _____ **Full Time/ Part Time/ Retired/ Student**

Employer Address _____

Emergency Contact Person _____

Contact Person Home Phone# _____ **Work Phone#** _____

Contact Person Address _____

Insurance Information: (check one)

Work Comp ___ **Auto** ___ **Medicare** ___ **Medicaid** ___ **Medical** ___ **Other** ___

Insurance Company _____

Name of Policy Holder _____ **Date of Birth** _____

Policy/ID/Claim Number _____ **Group Number** _____

Attorney Name/Address _____

I authorize Dakota Rehabilitation Center to release information to my insurance carrier, case manager or reviewer, or third-party payer who requests this information in order to process my claim for payment. I understand that I am financially responsible for any charges not covered by insurance. I authorize the release of information to physicians and facilities for the purpose of continued health care. I understand that I am responsible for my personal valuables while attending therapy at Dakota Rehabilitation Center. I hereby release this facility from any liability from loss by theft or negligence. I give authorization for care and treatment prescribed and considered necessary. I further acknowledge that no guarantees have been made to me as a result of treatment.

Signature _____ **Date** _____

Parent/Guardian Signature (if patient is under 18 years) _____

Payment for treatment received in this office may be made by cash, check, charge card, or insurance. We will gladly fill out insurance claims and assist you in receiving the maximum benefit from your program. All programs, however, have limitations, and some may not cover 100% of your fees for our services. Please remember that although we will assist you with your claim, you must assume ultimate responsibility for payment.

Hereforth:

1. I agree to pay the amount charged by the therapist for all professional treatment and services to the undersigned, his/her family or to the patient.
2. Ninety days after closing date: I agree to pay this office a Finance Charge of 15% per year.
3. This Finance Charge will be applied to my adjusted balance (remaining balance after deducting current payments and / or credits appearing on my statement).
4. I can avoid a Finance Charge by paying my account balance in full upon receipt of the statement provided that payment is actually received by this office before the next billing date. This allows for a maximum of 90 days from last date of service to pay my account without incurring a Finance Charge.
5. If this treatment is due to injuries sustained in a motor vehicle accident or other accident where there is third party liability and there is litigation involved, I understand that this office may submit claims to my personal medical insurance at my request. However, I understand that my personal medical insurance it is only a temporary payment system and upon settlement of my claim, all charges will be paid in full.

Furthermore:

I hereby authorize payment of my insurance benefits directly to the office of Dakota Rehabilitation Center. I realize that I am financially responsible to this office for all charges not covered by this assignment. If the fee-for-service is not paid within 90 days, I agree to bear collection costs as outlined above.

Insured or Guardian's Signature

Patient's Signature