Atlantic Rehabilitation Center

Physical Therapy
Occupational Therapy
Athletic/Personal Training
Performance Training
Massage Therapy

To ensure that we are filing the correct insurance please answer the following questions.

1. Injury related to an auto accident? Yes / No

If yes, Name of Auto Insurance Company: _____

2. Do you have legal representation (attorney)? Yes / No

If yes, please complete attorney information below:

Attorney Name: _____Name of Law Practice: _____
Address: _____Phone Number: _____

3. Do you have a letter of exhaustion from your Auto Carrier? Yes/ No
Can you provide us with a copy? Yes/ No

4. Do you have medical / health insurance? Yes / No
If yes, name of health insurance carrier

Insurance Company Name: _____Name of Primary Insured: _____

Phone Number: _____ID number: _____

5. Injury related to a work accident? Yes/No
If yes, name of employer and address at time of injury:
Name: _____
Address: _____

6. Have you received therapy for the same illness / injury in the last year? Yes/No
If yes, name of facility: _____ Dates Treated: _____

7. Are you (or have you) currently receiving any type of home health services? Yes/ No
Name of Home Health Agency: _____Date Discharged: _____
Name of physician who referred you to therapy: _____ Phone: _____
Name of primary care physician: _____ Phone: _____

Benefits that we have received from your insurance carrier at the time of service are not a guarantee of benefits. The patient, legal guardian, or parent (if the patient is under 18 years old) will be responsible for the co-payment and the deductible at the time of service.

Patient/or Guardian Signature: _____ Relationship to Patient: _____

Print Name: _____Date: _____