ENROLLMENT FORM

The patient/guardian shall complete this form and submit it to the center prior to the Patient's first day of attendance. Information printed on this form shall be kept current.

PATIENT INFORMATION

Name (Last, First, MI)	Home Address (Street, City, State, Zip)	Telephone #	Date of Birth (mm/dd/yyyy)	Date of Evaluation

Name of Physician	Address (Street, City, State, Zip)

Name of other specialist involved in Patient's care

Physician	Specialty	Phone Number

Medical Diagnosis:

Medications:

Current therapy plan: PT OT ST Counseling Frequency:

History of illness:

EMERGENCY CONTACT

Relationship to Patient	Name Home Address (Street, City, State, Zip)	Telephone #	Cell Phone #	E-mail Address

INSURANCE INFORMATION

Primary Insurance Co.	Policy #	ID #	Group #
Policy Holder	Policy Holder SSN #	Secondary Insurance	Policy Holder DOB

CANCELLATION POLICY

I understand that Seaside Rehabilitation has given me a weekly appointment time which I agree to keep. If I am unable to keep my appointment, I understand that Seaside Rehabilitation has a 6-hour cancellation notice policy. If I do not cancel my appointment within 6 hours, I understand that I will be responsible for a $25 cancellation fee payable at my next scheduled appointment.

AUTHORIZATIONS

- I AUTHORIZE/ DO NOT AUTHORIZE Seaside Rehabilitation to discuss my evaluation results with my
  Δ Medical Doctors Δ other medical professionals Δ other rehab professionals
- I authorize the release of any medical or other information necessary to process insurance claims.
- I authorize payment of my medical benefits to Seaside Rehabilitation.
- I acknowledge receipt of the practice's "Notice of Privacy Practices."
- I understand that I am financially responsible for all services performed by the therapists. I am responsible for all services deemed not covered or denied by my insurance company.
- Any copayment due at time of visit and not paid at that time is subject to a $5.00 service charge.
- Any balance sent for collection will be charged the state's maximum allowable interest rate.
- I understand that Seaside Rehabilitation has a 6-hour cancellation notification requirement. I also understand that if I cancel in less than 6 hours of my appointment, I am responsible for a $25 cancellation fee.
- I understand that if my Patient misses more than 3 sessions per quarter, that he/she may be discharged from therapy until I/we can commit to another time/day/date in which we can participate in therapy on a more consistent basis.
- I understand that failing to disclose all insurance information will result in my being responsible for all unclaimed fees.

Client's Signature: _____ Date: _____