



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
(First) (MI) (Last)

Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender **M** \_\_\_\_\_ **F** \_\_\_\_\_

Vocational Category: **Unemployed** \_\_\_\_\_ **Employed** \_\_\_\_\_ **Student** \_\_\_\_\_ **On Disability** \_\_\_\_\_ **Retired** \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Reminder Method:** Best way RHS can reach you for confirming appointment? **Home** \_\_\_ **Cell** \_\_\_ **Work** \_\_\_ **Email** \_\_\_

E-mail Address \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Marital Status **S** \_\_\_\_\_ **M** \_\_\_\_\_ **D** \_\_\_\_\_ **W** \_\_\_\_\_

**ARE YOU A VETERAN:** YES \_\_\_\_\_ NO \_\_\_\_\_ **Did the VA refer you?** YES \_\_\_\_\_ NO \_\_\_\_\_

**EMERGENCY CONTACT**

Name of Contact \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN** \_\_\_\_\_ Phone: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION** *Name of Ins. Co.:* \_\_\_\_\_

Subscriber or ID# \_\_\_\_\_ Group Number \_\_\_\_\_

Name of INSURED \_\_\_\_\_ Employer of INSURED \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**SECONDARY INSURANCE** *Name of Ins. Co.:* \_\_\_\_\_

Subscriber or ID# \_\_\_\_\_ Group Number \_\_\_\_\_

Name of INSURED \_\_\_\_\_ Employer of INSURED \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**WORKER'S COMP. INSURANCE CARRIER** \_\_\_\_\_

Case Manager \_\_\_\_\_ Claim # \_\_\_\_\_

Phone # of Case Manager: \_\_\_\_\_ Injury Date: \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_



**QUESTIONS FOR THE PATIENT**

Have you ever received the same or similar device before? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If **YES**, **WHEN** and **WHERE** was it dispensed from? Company name \_\_\_\_\_

Approximate date \_\_\_\_\_

Was item returned? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ If **YES**, what was the return date? \_\_\_\_\_

Is item being replaced? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**MEDICARE PATIENTS ONLY**

Are you enrolled in a Medicare HMO/Managed Care Program? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Has the patient been enrolled in a Medicare HMO/Managed Care program and now planning on returning to the Traditional Medicare Part B? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**PATIENT ASSIGNMENT OF BENEFITS/MEDICAL INFO. RELEASE CONSENT**

My signature below hereby requests that payment of all authorized Medical benefits be made to **Restorative Health Services, Inc.**, on my behalf for any and all services furnished to me by **Restorative Health Services, Inc.** I authorize any holder of medical information about me to be released to **Restorative Health Services, Inc.**, and its agents any information needed to determine these benefits or for the requirements of **Restorative Health Services, Inc.**, the benefits payable for related products and services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance or not. Any legal fees or collection fees incurred to collect this account **will be added to the outstanding balance and become part of the new balance owed to Restorative Health Services, Inc.**

I understand that an authorization for services and products by my insurance carrier is **not** a guarantee of benefits or payment by the insurance carrier. Final eligibility will be determined at the time the claim is received by my insurance carrier. Benefits are subject to all contract terms, conditions, exclusions and to a patient’s eligibility at the time products and services are rendered which is known as the “Date of Service”. Any benefit or eligibility information received prior to claim receipt and adjudication by the carrier is solely an estimate and not definitive.

_____	_____	_____
Print Name	Signature	Date

_____	_____	_____
Representative Print Name	Representative Signature	Date

PLEASE CHECK ONE OF THE FOLLOWING PERMISSION STATEMENTS:

\_\_\_\_\_ Permission **IS** given for RHS to contact me by mail, phone, or voice mail message, to schedule, re-schedule, or remind me of appointments or to inform me of any insurance carrier information pertinent to my service or product being rendered.

\*\*Please give us the name of the person(s) to whom we can share Restorative Health Services, Inc. information with if you are unable to answer the call: \_\_\_\_\_

\_\_\_\_\_ Permission **IS NOT** given to Restorative Health Services, Inc. to contact me by mail, phone, or voice mail, to schedule, re-schedule, or remind me of appointments or inform me of an insurance authorization that may be expiring.

**I was offered Restorative Health Services, Inc. Privacy Practices.**

**I was informed of and offered a copy of the Medicare Supplier Standards.**

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Representative Print Name	Representative Signature	Date