ASSESSMENT REHABILITATION
MANAGEMENT, INC.
Call: (517) 394-0775
for your ergonomic solutions
3333 S. Pennsylvania Ave., • Suite 100 • Lansing, MI 48910

ARM ASSESSMENT REHABILITATION MANAGEMENT

Please provide the following information for our records and be prepared to show all insurance cards to our receptionist. Thank you for your cooperation.

Patient Information Forms-Internet

PATIENT'S NAME:_____ CASE NUMBER:_____

(Last) (First) (Middle)

DATE OF BIRTH:_____ SEX: M OR F SOCIAL SECURITY NO:_____

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

HOME PHONE:_____ WORKPHONE:_____

FOR CHANGE OF ADDRESS ONLY:_____

_____

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

MARITAL STATUS: S M D W NAME OF SPOUSE:_____

NAME OF PARENTS, *IF PATIENT IS A DEPENDENT*:_____

CITY, STATE, ZIP CODE:_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:_____

RELATIONSHIP TO PATIENT:_____ TELEPHONE:_____

REFERRED BY:_____ **ADDRESS:**_____
PHONE #:_____
PRIMARY CARE
PHYSICIAN:_____ **AUTHORIZATION#**_____

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PLEASE BE PREPARED TO SHOW ALL INSURANCE CARDS AND DRIVERS LICENSE (OR STATE ID) TO THE RECEPTIONIST. IS THIS INJURY/ILLNESS RELATED TO; AUTO ACCIDENT, WORK RELATED, OR OTHER ACCIDENT? (CIRCLE) YES NO

PRIMARY INSURANCE:_____

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

POLICY NUMBERS:_____ CONTRACT NUMBER:_____

SUBSCRIBER:_____ DATE OF BIRTH:_____

RELATIONSHIP TO SUBSCRIBER TO PATIENT:_____

EMPLOYER OF SUBSCRIBER (*IF DIFFERENT THAN ABOVE*):_____

ADDRESS OF EMPLOYER (*IF DIFFERENT THAN ABOVE*):_____

SECONDARY INSURANCE:_____

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

POLICY NUMBERS:_____ CONTRACT NUMBER:_____

SUBSCRIBER:_____ DATE OF BIRTH:_____

RELATIONSHIP OF SUBSCRIBER TO PATIENT:_____

EMPLOYER OF SUBSCRIBER (*IF DIFFERENT THAN ABOVE*):_____

ADDRESS OF EMPLOYER (*IF DIFFERENT THAN ABOVE*):_____

OTHER INFORMATION:_____

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I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES THAT ARE REFERRED TO ME. I UNDERSTAND THAT ARM ASSESSMENT REHABILITATION MANAGEMENT WILL BILL MY INSURANCE BUT THAT I AM RESPONSIBLE FOR ANY BALANCE THAT MY INSURANCE DOES NOT PAY AND ANY COPAYMENTS AND/OR DEDUCTIBLES.

SIGNATURE:_____ **DATE:**_____

I, _____ **AUTHORIZE THE RELEASE OF ANY MEDICAL**

(PATIENT'S NAME)

INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM TO ARM ASSESSMENT REHABILITATION MANAGEMENT AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO THEM FOR SERVICES RENDERED, WHEN THEY REQUEST THOSE PAYMENTS BE MADE DIRECTLY TO THEM.

SIGNATURE:_____

MEDICARE NUMBER:_____ **DATE:**_____

(IF APPLICABLE)