The Howell Rehab Center

Patient Information

Information needed for the patient

Patient Last Name	Patient First Name	
Patient Address	City, State & Zip Code	
Patient Home Phone	Patient Cell Phone	Patient Email Address
Patient Date of Birth	Patient Sex ☐ Male ☐ Female	Patient Social Security Number

What is the relationship of the patient to the cardholder? (please check one)

☐ Holder of Insurance (Self) ☐ Spouse ☐ Dependent ☐ Other ☐ No Insurance

Marital Status

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Legally Separated

Employed ☐ Full Time ☐ Part Time ☐ Retired ☐ No	Student ☐ Full Time ☐ Part Time
Employer	Employer Phone
Have you had therapy elsewhere this year? ☐ Yes ☐ No	Did you have home health care this year? ☐ Yes ☐ No
Referring Physician Name	Who may we thnak for referring you?

Is your health insurance part of the Affordable Care Act Insurance Plans?

☐ Yes ☐ No

Responsible Party

Information needed for the person who's name is on the card

Cardholder Last Name	Cardholder First Name	
Address	City, State & Zip Code	
Social Security Number	Date of Birth	Home Phone
Employer	Employer Phone	
Is this related to employment?	Auto Accident?	
Primary Insurance Carrier Name ☐ Yes ☐ No	Secondary Insurance Carrier Name ☐ Yes ☐ No	

I acknowledge that I am responsible for payment in full to The Howell Rehab Center for services rendered. I also authorize that benefits from insurance carriers and or Medicare be paid directly to The Howell Rehab Center. I authorize The Howell Rehab Center to release any information requested by my insurance carrier and/or Medicare. By signing this form I give my consent for treatment from associates at The Howell Rehab Center. I understand and am aware of the Howell Rehab privacy policies and that I may request a copy of the privacy policy at any time. Failure to cancel appointment will result in a $25 fee.

Signed Date