# 

Please provide your insurance card, photo identification, and referral for physical therapy.

**Patient Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Daytime/Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Parent Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Referral\_\_\_\_\_\_\_\_

Have you had Physical or Speech Therapy, this calendar year? □Yes □ No If yes, how many visits\_\_\_\_\_\_\_

Nature of problem\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about CMR? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Primary Insurance Carrier** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group No.\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Insured\_\_\_\_\_\_\_\_

**Secondary Insurance Carrier** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group No.\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Insured\_\_\_\_\_\_\_\_

**If the injury is Auto or Work related please compete the following Information**: Auto/Work Date of Injury\_\_\_\_\_\_

Carrier Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact/Adjuster Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treat/Assignment of Benefits/Release of Information/HIPAA Acknowledgement**

**I hereby authorize Central Michigan Rehabilitation, LLC (CMR) to provide treatment as prescribed by my physician. Treatment may be provided in the clinic, at my home, or through the use of Evisits or Telerehabilitation. I understand that I am responsible for my deductible, co-pays, or cost share requirements made by my insurance carrier. I am responsible for verifying my insurance requirements. I request that payment from my insurance carrier to be made to Central Michigan Rehabilitation. I agree to be responsible for the full amount of charges if my insurance carrier does not pay for charges in a timely manner or if I fail to provide necessary information needed to submit or process the insurance claim on my behalf. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment and payment. I have received The Notice of Privacy Practice for CMR (HIPAA).**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



Central Michigan Rehabilitation is interested in the total wellbeing of our clients. In keeping with that philosophy, we feel that sometimes social worker intervention may be appropriate. During your treatment you, your physician, therapist or our social worker may agree that this service may be beneficial to you. Our social worker is available by appointment to evaluate the social or vocational factors involved in your rehabilitation, to counsel and advise you on problems that are arising from your illness or your injury, and to make appropriate referrals for services that maybe required. You may schedule these services through your therapist or through the receptionist.

Please answer the following questions as part of your Initial Evaluation and to assist us to determine whether you might benefit from social or vocational benefits:

Are you interested in speaking with a Social Worker? Yes No

Are you out of work due to your illness or injury? Yes No

Are you experiencing stress due to your illness or injury? Yes No

Are you your primary caregiver? (no one else is in the home helping you with daily activities) Yes No

Are you a caregiver for someone else? (Children or spouse) Yes No

Are you receiving any social work, psychological or vocational counseling at this time? Yes No

Do your symptoms **prevent** you from performing daily tasks such as?

Self-Care Yes No

Driving Yes No

Grocery Shopping Yes No

House Keeping Yes No

Preparing Meals Yes No

**Patient Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Health Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason for Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following regarding yourself or your immediate family (parents/siblings)**

**SELF FAMILY SELF FAMILY**

**Cancer Yes No Yes No Diabetes Yes No Yes No**

**High Blood Pressure Yes No Yes No Angina/Chest Pain Yes No Yes No**

**Stroke Yes No Yes No Osteoporosis Yes No Yes No decreased bone density**

**Rheumatism Yes No Yes No Thyroid Problems Yes No Yes No**

**Please list any medical history and Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any allergies?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the past 3 months have you had or experienced:**

A change in your health? Yes No Upper Respiratory infection? Yes No

Nausea/Vomiting? Yes No Difficulty in Swallowing? Yes No

Shortness of breath? Yes No Dizziness? Yes No

Fever/Chills/Sweats? Yes No Unexplained weight change? Yes No

Numbness or Tingling? Yes No Change in appetite? Yes No

Change in bowel/bladder function? Yes No Do you have a pacemaker? Yes No

**Are you currently (circle): Pregnant Depressed Under Stress Sensitive to latex?**

**Do you have problems with (circle): Hearing Vision Speech Communication**

**Date of last physical examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please list any surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of onset of pain/symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Where is the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was the cause of the pain/symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes it feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes it feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe the pain (dull, sharp, radiating, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**A picture containing diagram

Description automatically generatedPain Scale (1-10; 0 being no pain 10 being emergency room pain) (Circle area of pain)**

* Current:
* Best:
* Worst:



**Financial Agreement**

The staff at Central Michigan Rehabilitation would like to thank you for allowing us to treat your rehabilitation needs. We strive to treat each of our clients individually, using the most up to date techniques to meet all of your rehabilitation goals.

To receive the maximum benefit from your physical therapy, it is of the utmost importance that you attend your therapy appointments and follow any home exercise programs that the therapist recommends based on your physician orders. If you cannot make your scheduled physical therapy appointment, you must give us a reasonable amount of time for cancelation. **If you choose not to do so you will be charged a $25.00 cancelation fee that WILL NOT be billed to your insurance carrier. Please know, that before you are seen for your next visit, the fee has to be paid. If you CANCEL/NO SHOW 3 or more visits you may be discharged from this practice.**

**Reminder Call: YES/NO TEXT or Call (circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(number) or email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Insurance:** Central Michigan Rehabilitation, LLC has contracted rates with several insurance carriers, and we bill them as a courtesy to you. As the policy holder, you are responsible if your carrier declines payment for any reason. You are also responsible for any cost share requirements made by your carrier. It is the responsibility of the client to verify physical therapy benefits, deductible, co-pay, co-insurance, or any other cost share requirements made by your insurance carrier. Benefits may also include evisits or Telerehabilitation and I agree to those services if needed.

**I understand it is my responsibility to verify my insurance coverage**. If I find the benefit information differs from the above information, I will notify Central Michigan Rehabilitation. I also understand that if I do not pay my balance due in a timely manner, my account may be turned over to collections or I may be petitioned in Small Claims Court for payment. **Non-Payment on Account:** Should collection proceedings or other legal action become because of non-payment on physical therapy services, the patient or responsible party understands that CMR has the right to disclose to an outside collection service all relevant person information necessary to collect payment. The patient or responsible party understands that they will be responsible for all costs of collection including but not limited to, court fees, service fees, collection fees, interest due (18%APR), and any Attorney fees.

**Care Credit:** Central Michigan Rehabilitation, LLC proudly extends Care Credit to any client that is approved. The approval is easy. We can enroll you here or you may enroll at your convenience at home. Please see one of your office staff with any questions that you have.

**Physical Therapy Packages:** With the cost of healthcare on the rise, Central Michigan Rehabilitation, LLC can provide you with the therapy that you need in a package that is easier to afford. This is a great option if you are uninsured, under insured. The package can be applied to a Care Credit Card or a Major Credit Card. We even accept check or cash. The package is paid for on the first day of physical therapy.

**Initials\_\_\_\_\_\_\_\_**

**\*\*IT IS YOUR RESPONSIBILITY TO VERIFY YOUR INSURANCE COVERAGE\*\***

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Verified with Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CMR Staff Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARRIER**- Representative verifying information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ online verification yes/no

Deductible $ \_\_\_\_\_\_\_\_\_ Met $ \_\_\_\_\_\_\_\_\_\_Remains $ \_\_\_\_\_\_\_\_\_\_ Co-pay $\_\_\_\_\_\_\_ Max Co-pay due$\_\_\_\_\_\_\_\_\_

Co-insurance \_\_\_\_\_\_\_\_\_\_% Max Co-Insurance $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Insurance Remaining $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coverage details (visits, send medical docs., etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is authorization required with insurance carrier? \_\_\_\_\_\_\_\_ Authorization Department Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized By\_\_\_\_\_\_\_\_\_\_\_\_ Authorization Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Visits \_\_\_\_\_\_\_Date Range\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY CARRIER**- Insurance Representative verifying information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible $ \_\_\_\_\_\_\_\_ Met $ \_\_\_\_\_\_\_\_\_Remains $ \_\_\_\_\_\_ Co-insurance \_\_\_\_\_\_\_\_% Max Co-insurance $\_\_\_\_\_\_\_

**I understand it is my responsibility to verify my insurance coverage**. If I find the benefit information differs from the above information, I will notify Central Michigan Rehabilitation. I also understand that if I do not pay my amount due in a timely manner, my account will be turned over to a collection agency.

If you have any questions regarding the above information please do not hesitate to ask. Thank you for your cooperation and understanding.

Please sign below indicating that you have read and understand the above information.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Debit/Credit Card Authorization (optional)**

Name on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Card Type (Circle) Visa Master Card

Card No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date\_\_\_\_\_\_\_ Security Code\_\_\_\_\_\_ Billing zip code\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, here by authorize Central Michigan Rehabilitation, LLC to utilize the above credit card information to pay for physical therapy services rendered at Central Michigan Rehabilitation, LLC or no show fees because I did not provide 24 hours’ notice for cancelation. I authorize CMR to bill my credit card on a weekly/monthly basis until my outstanding balance has been satisfied. I may authorize CMR to bill my credit card on a re-occurring basis until my outstanding balance has been satisfied. I agree to \_\_\_\_\_\_\_\_payments in the amount of \_\_\_\_\_\_\_\_ to be charged on this card. I understand that the last payment will be the remaining balance after the equal payments have been collected.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**