

BAIG REHABILITATION SERVICES INC.

Saginaw

Bay City

PT. # _____ Admit Date: _____

Patient Information

Name: _____ Date of Birth: _____

(Last) (M) (First)

Address: _____ Phone # _____

(Street) (City) (Zip)

Social Security # _____ M F Marital Status: _____

Employer: _____ Phone # _____

Physician: _____ Date of Onset: _____

Insurance Information

Primary Insurance

Subscriber's Name: _____

Insurance Name: _____ Contract # _____ Group # _____

Secondary Insurance

Subscriber's Name: _____

Insurance Name: _____ Contract # _____ Group # _____

* IS THIS A WORK RELATED INJURY? YES NO Date of injury: _____

CLAIM # _____ Company Name: _____

Send billing to: _____

* IS THIS A WORK RELATED INJURY? YES NO Date of injury: _____

CLAIM # _____ Company Name: _____

Send billing to: _____

Family Information

Spouse or Guardian: _____ Phone # _____

Authorizations

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO BAIG REHABILITATION. IF PAYMENT IS SENT DIRECTLY TO ME/SUBSCRIBER, I WILL PROMPTLY SUBMIT THE SAME TO BAIG REHABILITATION.

AUTHORIZATION TO TREAT: I HEREBY AUTHORIZE BAIG REHABILITATION TO RENDER THE TREATMENTS AS PRESCRIBED BY MY PHYSICIAN.

AUTHORIZATION TO RELEASE: I HEREBY AUTHORIZE BAIG REHABILITATION ANY INFO ACQUIRED IN THE COURSE OF MY EXAM OR TREATMENT.

AUTHORIZATION TO PHOTOCOPY: I AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE AS THE ORIGINAL. I HEREBY ACKNOWLEDGE I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL TREATMENTS RENDERED NOT COVERED BY AN INSURANCE PLAN.

(SIGNATURE)

(DATE)