

North Hagerstown Rehabilitation
580 Northern Avenue, Suite F
Hagerstown, MD 21742

****Please print in black ink****

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

DOB: _____ Age: _____ SSN: _____ - _____ - _____ Sex: M/F Marital Status: M/S

Do you work outside the home: Y/N/Retired Are you a student: Full time/Part time/No

Responsible Party (for minors only): _____

Employer Name: _____

Emergency Contact & Phone: _____

Attorney Name & Phone (if applicable): _____

Area to be treated: _____ Surgery/Injury Date: _____

Primary Care Physician: _____

Referring Dr.: _____

How did you hear about us?: _____

Assignment of insurance, benefits, release of information and authorization to treat; and the responsibility for payment, assignment of benefits authorization and medical release: I, the undersigned, do hereby expressly guarantee payment in full of any and all claims and charges in consideration for medical services rendered to, or to be rendered to me by North Hagerstown Rehabilitation. I hereby authorize and demand the assignment of my basic medical, major medical, auto medical, third party medical or any other medical benefits that may apply, herein specified and otherwise payable to me, directly to North Hagerstown Rehabilitation. I authorize North Hagerstown Rehabilitation to release medical information acquired in the course of my treatment and examination to my insurance company. If for any reason the account should become delinquent, I agree to pay all rebilling charges, interest charges, collection of costs and reasonable legal fees. I understand and agree to the North Hagerstown Rehabilitation payment policies.

Signature: _____ Date: _____