



6820 Veterans Blvd. Suite A
Metairie, Louisiana 70006
504-887-7463 office
504-887-7115 fax

REGISTRATION INFORMATION

Type of Service

What service will you be receiving at Superior Rehabilitation?

- Physical Therapy, Orthotics, Wellness Visit

Patient's Information

First Name, Middle, Last Name, Date of Birth, Sex, Street Address, City, State, Zip, Home Phone, Cell Phone, Email Address, Referring Doctor, Primary Care Physician, Complaint/Diagnosis, Date of Accident, Status, Social Security No., Employer, Employer Address, Employer Phone, Have you ever been treated at Superior before?, Have you ever received physical therapy before?, How did you hear about us?

Insurance Information

First Policy:

Insurance Company, Name of Insured, Phone No., Policy, Group

Second Policy:

Insurance Company, Name of Insured, Phone No., Policy, Group

Assignment of Benefits

I hereby instruct and direct the above mentioned insurance company to pay: Superior Rehabilitation

P. O. Box 74860
Metairie, LA 70033

If my current policy prohibits direct payment to the provider, I hereby, also instruct and direct you to pay me and mail it as follows:

In Care Of:
Superior Rehabilitation
P. O. Box 74680
Metairie, LA 70033

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee. I also authorize the release of any information pertinent to my case to any physician, insurance company, case manager, adjuster, attorney, or employer involved in the case. A photo copy of the assignment shall be considered as effective and valid as the original. I understand that my liabilities for services will be limited to a copay of \$ per visit, or a deductible of \$ (of which approximately \$ has been met) and/or % of the authorized allowed amount which will be assessed by your insurance company.

Person Responsible for Bill

Name, Relationship to Patient

Emergency Contact

Please list the name of a relative or friend that can be contacted in case of an emergency.

Name, Relationship, Phone No.

Signature, Date, Witness