Neurologic Therapy Specialists, LLC
Dba Touchstone Rehabilitation

PATIENT DEMOGRAPHIC INFORMATION

Today's Date:_____

IMPORTANT: ARE YOU RECEIVING HOME HEALTH CARE FOR ANY REASON? _____
If so, what service? (nurse, therapist, aide)_____ What company?_____

Patient Information

Patient Name _____
Last First Middle Initial

Gender: M _____ F _____ Date of Birth _____/_____/_____ Age _____

Primary Language: English □ Other □_____ Race/Ethnicity:_____

Social Security Number _____ - _____ - _____ Marital Status: S M W D Sep

Local Address _____

City _____ State _____ Zip Code _____ Local Phone (___)_____

Permanent Address _____

City _____ State _____ Zip Code _____ Permanent Phone (___)_____

Cell Phone _____ Email _____

Date of Injury / Stroke_____/_____/____ Name of Spouse/Parent/Guardian (circle one)_____

Type of Injury: (circle) Auto Accident - Fall - Surgery related- Sports Injury- Other – Other Accident
None of Above

How did you hear of us or who referred you?_____

EMERGENCY CONTACT: _____ Relationship _____

Phone(s) (____) _____ Cell Phone (_____) _____

Physician Information

Referring Physician _____ Phone (_____) _____

Fax (_____) _____

Office Location: Street Address _____

City _____ State _____ Zip _____

Patient's Primary Physician _____ Phone (_____)_____

Responsible Party Information

Name:_____

Employer: _____ Occupation _____

Street Address _____

City _____ State _____ Zip _____

Claim Number:_____

Insurance Information

Primary Insurance Company: _____

Street _____City _____ State _____ Zip Code _____

ID# _____ Policy # _____Group # _____

Policy Holder's Name _____ Relationship to Patient _____

SS # _____-_____-_____ Date of birth _____

Policy Holder's Address (if other than patient's):

Street _____City_____ State _____Zip Code _____

Policy Holder's Employer:

Street _____City_____ State _____Zip Code _____

Claim Number:_____

Secondary Insurance Company: _____

Street _____City _____ State _____ Zip Code _____

ID# _____ Policy # _____Group # _____

Policy Holder's Name _____ Relationship to Patient _____

SS # _____-_____-_____ Date of birth _____

Policy Holder's Address (if other than patient's):

Street _____City_____ State _____Zip Code _____

Policy Holder's Employer:

Street _____City_____ State _____Zip Code _____

Assignment of benefits/authorization to release information

I authorize payment of my insurance benefits directly to Neurologic Therapy Specialists, LLC. I understand I am personally responsible for balances not paid by my insurance. I understand I am responsible to know my insurance benefits under my policy and payments for which I may be responsible.

x_____/_____/_____
Patient/Responsible Party Date

I authorize Neurologic Therapy Specialists, LLC to release any medical records to myself or those clinicians necessary to assist with coordination of care or the processing of my claim. I also authorize Neurologic Therapy Specialists, LLC and the treating clinicians to communicate with other treating medical clinicians regarding my care. I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Neurologic Therapy Specialists, LLC and have received one if I chose to have a copy.

I voluntarily consent to receive treatment for my condition according to my treatment plan. I have been informed by my therapist or physician about significant risks, benefits and alternatives to the procedures and have had my questions answered. I further understand that I may rescind this consent at any time and will be informed of the potential consequences of that decision.

x_____/_____/_____
Patient/Responsible Party Date