

## PATIENT INFORMATION/FINANCIAL RESPONSIBILITY

Date: \_\_\_\_\_

PATIENT NAME: [ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms. \_\_\_\_\_  
Last Name First Name Middle Initial

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SOCIAL SEC. #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

SPOUSE/PARENT NAME: \_\_\_\_\_ SOC. SEC #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ FAM. PHYSICIAN: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOW WERE YOU REFERRED TO THIS OFFICE? \_\_\_\_\_

FORME Medical and Rehabilitation of Findlay, Inc will file for all the insurance benefits for which you or your minor child (under the age of 18) are eligible. Please have all of the patient's insurance cards ready for photocopying when you reach the check-in counter (including Medicare and Medicaid). Your signature on the line below gives FORME Medical and Rehab Center of Findlay the right to act on your behalf when filing for insurance:

**CONSENT FOR TREATMENT:** I authorize the physicians at FORME Medical & Rehab to provide medical and surgical care to myself and/or my minor children. The signed statement will serve as my authorization for the treatment of my minor children if I am unavailable. I authorize all diagnostic testing including laboratory studies and x-ray studies as well as any treatment modality that the physician deems appropriate in my medical care. I acknowledge that if any medical problem occurs during the hours that FORME Medical & Rehab is not open, I have been advised to be evaluated and treated at a hospital emergency room or by another physician of my choice.

**RECORDS RELEASE:** FORME Medical & Rehab Center has your permission to release your records to insurance companies if necessary to facilitate your claim.

**FINANCIAL RESPONSIBILITY:** I hereby acknowledge and accept financial responsibility for all medical services rendered to me and/or my minor children, by the physicians at FORME Medical & Rehab Center. I agree to remit payment in full at the time of services rendered.

**COLLECTIONS:** I acknowledge and understand that I will be financially responsible for all costs associated with collections in the event that I fail to pay for any medical services rendered to myself and/or minor child/children and legal action is instituted.

Your signature means that you understand and agree to the following:

\_\_\_\_\_  
Patient Signature, POA for Patient, or Parent of minor Date