

**EDGE Rehabilitation and Wellness**

2360-C Montebello Sq. Drive, Colorado Springs, CO 80918

Tel: 719-599-5330 / Fax: 719-599-5438



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Home address: \_\_\_\_\_ zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring physician: \_\_\_\_\_ Primary care physician: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Work comp: Yes \_\_\_ No \_\_\_ Auto: Yes \_\_\_ No \_\_\_

**Primary Insurance Co:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Social security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID#: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Policy/Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance contact name: \_\_\_\_\_ phone: \_\_\_\_\_

**Secondary Insurance:** Yes \_\_\_ No \_\_\_ If Yes, Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Subscriber's name: \_\_\_\_\_

ID#: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Policy/Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance contact name: \_\_\_\_\_ phone \_\_\_\_\_

Your insurance is a contract between you and your insurance company. As a courtesy to you, we will bill most insurance companies for the services provided. We cannot guarantee the coverage of your particular plan and it is your responsibility to verify your insurance coverage. As well, it is your responsibility to pay the deductible, co-insurance, and other balances not paid by your insurance company. Unless prior arrangements have been made, you agree to pay the charges within 30 days after receipt of statements. In the event legal action is necessary to collect an unpaid balance, you will be responsible for costs for collecting monies owed, including court, collection agency, and attorney fees.

The information provided on this form is hereby certified by me to be true and correct. I agree to let **Rea Rehabilitation Services, Inc.** know of any changes to the information contained herein. I have read all information completely and understand it.

Patient/Responsible Party (signature): \_\_\_\_\_ date \_\_\_\_\_

Witness \_\_\_\_\_ date \_\_\_\_\_