C.O.A.S.T Rehabilitation Service, inc
Patient Registration Form

Patients Name Todays Date

Parents Name - if minor Parents Phone

Address Home Phone

City State Zip Code Mobile Phone

Date of Birth M/F Marital Status - S/M/D/W

Employer Spouse/Partner Name Occupation

Employer Address Employer Phone

Date of Injury/ Date of Surgery

Referred by Address

Phone

PRIMARY INSURANCE

Name of Primary Insured DOB

Insurance Provider

ID # Social Security #

SECONDARY INSURANCE

Name of Primary Insured DOB

Secondary Insurance Provider

ID # Social Security #

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I hereby instruct my insurance company/companies or attorney to pay directly to **COAST Rehabilitation Services**, Inc any benefits allowable for their professional services rendered to me at their facility. Any sum of money paid under the assigment shall be credited to my account. I also assume all responsibility for any balance on my account and agree to pay any additional charges equal to the coast of collection including agency, attorney fees and and court costs incurred and permitted by laws governing these transactions. Interest on unpaid balance will be charged at 18% per month on accounts past 60 days. I also authorize **COAST Rehab Services, Inc.** to provide any all all information that insurance may require to facilitate this process.

Date: Patient/Parents Signature