Patient Personal Information

_____ _____ _____

Last Name First Name Middle Initial

_____ _____-___-_____

Date of Birth (mm/dd/yyyy) Social Security #

_____

Street Address City State Zip

_____ _____

Phone # Email Address

_____ _____

Emergency Contact Name Emergency Contact Phone #

Insurance Information

	Commercial	Medicaid	ID #
☐ Aetna	☐	☐	_____
☐ Coventry Cares	☐	☐	_____
☐ Gateway	☐	☐	_____
☐ Health America	☐	☐	_____
☐ Highmark	☐	☐	_____
☐ UPMC	☐	☐	_____
☐ Other	_____		

_____ _____ _____

Insurance Guarantor Insurance Birthdate Relationship

___ I do not have insurance. I agree to pay Recovery Care $50 per week ($200 per 28 day script). Recovery Care will not bill patients for visits and fee is payable at time ofvisit. Recovery Care accepts Cash, Money Order, and Credit Card/ATM Card.

___ I have a Co-Pay with my health insurance in the amount of _____. I agree to pay my Co-Pay at the time of visit.

Assignment of Benefits/Authority for Releases of Information/HIPAA Acknowledgement:

I request that payment authorized Medicare/Medicaid/or private insurance benefits be made to Recovery Care for any covered services furnished to me by this practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services. If this is a private insurance company claim, I future agree to be responsible for the full amount of the charges from the date of service if my private insurance company does not pay for the charges.

_____ _____

Patient Signature Date