ARM ASSESSMENT REHABILITATION MANAGEMENT
Please provide the following information for our records and be prepared to show all insurance cards to our receptionist.
Thank you for your cooperation.

PATIENT'S NAME:______________________________ CASE NUMBER:______________________________
(Last) (First) (Middle)

DATE OF BIRTH:____________ SEX: M OR F SOCIAL SECURITY NO:______________________________

ADDRESS:______________________________ CITY, STATE, ZIP CODE:______________________________

HOME PHONE:____________________ WORKPHONE:____________________ CELL PHONE: ____________________

*FOR CHANGE OF ADDRESS ONLY:*______________________________

EMPLOYER:______________________________ OCCUPATION:______________________________

ADDRESS:______________________________ CITY, STATE, ZIP CODE :______________________________

MARITAL STATUS: S M D W NAME OF SPOUSE:______________________________

NAME OF PARENTS, *IF PATIENT IS A DEPENDENT:*____________________ CITY, STATE, ZIP CODE :____________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:____________________ ___RELATIONSHIP TO PATIENT:____________________

TELEPHONE: (H)____________________ (C)____________________ (W) ____________________

REFERRED BY:____________________**ADDRESS:**______________________________Phone #:________________
PRIMARY CARE PHYSICIAN:______________________________**AUTHORIZATION#**________________
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PLEASE BE PREPARED TO SHOW ALL INSURANCE CARDS AND DRIVERS LICENSE (OR STATE ID) TO THE RECEPTIONIST. IS THIS INJURY/ILLNESS RELATED TO; AUTO ACCIDENT, WORK RELATED, OR OTHER ACCIDENT? (CIRCLE) YES NO

PRIMARY INSURANCE:______________________________

ADDRESS:______________________________ CITY, STATE, ZIP CODE:______________________________

POLICY NUMBERS:______________________________CONTRACT NUMBER:______________________________

SUBSCRIBER:____________________ DATE OF BIRTH:________ RELATIONSHIP TO SUBSCRIBER TO PATIENT:________________

EMPLOYER OF SUBSCRIBER (*IF DIFFERENT THAN ABOVE*):______________________________

ADDRESS OF EMPLOYER (*IF DIFFERENT THAN ABOVE*):______________________________

SECONDARY INSURANCE:______________________________

ADDRESS:______________________________ CITY, STATE, ZIP CODE:______________________________

POLICY NUMBERS:______________________________ CONTRACT NUMBER:______________________________

SUBSCRIBER:____________________ DATE OF BIRTH:________ RELATIONSHIP OF SUBSCRIBER TO PATIENT:________________

EMPLOYER OF SUBSCRIBER (*IF DIFFERENT THAN ABOVE*):______________________________

ADDRESS OF EMPLOYER (*IF DIFFERENT THAN ABOVE*):______________________________

OTHER INFORMATION:______________________________

(Insurance Information Continued from Page 1)

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES THAT ARE REFERRED TO ME. I UNDERSTAND THAT ARM ASSESSMENT REHABILITATION MANAGEMENT WILL BILL MY INSURANCE BUT THAT I AM RESPONSIBLE FOR ANY BALANCE THAT MY INSURANCE DOES NOT PAY AND ANY COPAYMENTS AND/OR DEDUCTIBLES.

SIGNATURE:____ DATE:_______________________________

I, ____ AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM TO ARM ASSESSMENT REHABILITATION MANAGEMENT AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO THEM FOR SERVICES RENDERED, WHEN THEY REQUEST THOSE PAYMENTS BE MADE DIRECTLY TO THEM.

SIGNATURE:________________________________ ____________________ DATE:________________________________

I, ______________________________AUTHORIZE ARM, INC TO LEAVE MESSAGES ON MY HOME, CELL, OR WORK PHONE TO INFORM OF APPOINTMENT CHANGES, CANCELLATIONS, OR REQUEST A RETURN CALL.

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NO SHOW APPOINTMENT POLICY:

AT ARM ASSESSMENT REHABILITATION MANAGEMENT, INC. WE UNDERSTAND THAT CIRCUMSTANCES DO NOT ALWAYS ALLOW PATIENTS TO KEEP SCHEDULED APPOINTMENTS. WE ASK OUR PATIENTS TO UNDERSTAND THAT THE THERAPIST'S TIME IS VERY VALUABLE IN CARING FOR ALL OF OUR PATIENTS. WHEN A PATIENT FAILS TO CANCEL A SCHEDULED APPOINTMENT IN ADVANCE, IT DENIES ANOTHER PATIENT ACCESS TO THAT APPOINTMENT TIME.

In an attempt to address this problem, the following "No Show for Appointment" policy has been adopted for those patients who choose not to cancel their appointments:

1. If you cannot keep your appointment with us, please inform us 24 hours in advance.
2. If an emergency arises we will accept a phone cancellation up to 2 hours prior to the scheduled appointment time.
3. The "No Show Appointment" will be noted in the patient chart.
4. Failure to cancel a scheduled appointment three (3) times in a 4 week period or establishing a pattern of "No Show Appointments" over a longer period of time may result in termination of therapist/patient relationship, thus requiring that the patient find another therapist/rehabilitation facility.
5. Failure to cancel a scheduled appointment the third time will result in a charge of $25.00 to your account. This charge will not be covered by your insurance.

Thank you in advance for your cooperation as you help us continue to give quality care in a timely manner to all our patients.

SIGNATURE: ____ **DATE:** _______________
(Patient or legal guardian)

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WE PARTICIPATE WITH THE FOLLOWING INSURANCE PLANS:

BCBS OF MI BCBS – PPO PPOM BCN BCN Advantage PHP MEDICARE MEDICARE + BLUE
MCLAREN HEALTH ADVANTAGE/COMMERCIAL HMO FIRST HEALTH AUTO WORKMANS COMP

- We are happy to bill your insurance carrier for you, even if we do not participate with them, if **ALL** insurance information is provided upon your initial visit.

- BECAUSE YOUR CONTRACT IS WITH YOUR INSURANCE, PAYMENT FOR ALL SERVICES RENDERED ARE LIKEWISE YOUR RESPONSIBILITY. THIS INCLUDES FOLLOW-UP CONTACT WITH THEM, AS WELL AS PAYMENT OF ANY CO-PAYS, DEDUCTIBLES, OR ANY NON-COVERED CHARGES INCURRED.

- Should your balance remain unpaid longer than 90 days, and we have not heard from you to make payment arrangements, or advise us of insurance activity, your account will be automatically forwarded to a local collection agency until your balance is resolved.

- IF YOU HAVE ANY QUESTIONS, PLEASE CALL SHELLY IN OUR BILLING DEPARTMENT AT (517) 394-0775 BETWEEN THE HOURS OF 7:30AM AND 5:00PM MONDAY – THURSDAY.

I UNDERSTAND AND ACCEPT THESE TERMS:

SIGNATURE: ____ **DATE:** _______________