MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Patient Information

Last Name: _____ First Name: _____Middle Initial: ____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of Emergency Contact: _____ Phone Number / Address of Emergency Contact: _____

Authorizations

I authorize any provider employed by Mid-Atlantic Brain and Neurological Rehabilitation, Inc. (MABNR), Dr. Lane and Dr. Jackson to treat me. _____initial

I authorize all payments to be made directly to Dr. Lane, Dr. Jackson and MABNR on the day of service. I consent to the release of all information the insurance company may request for filing their claims. I understand that I am responsible for billing my insurance company, but many insurance companies do not cover all charges and that I am responsible for and will pay for all charges on the date of services provided by Dr. Lane, Dr. Jackson and MABNR. _____initial

I have received and reviewed the handout called Privacy Practices Notice. I understand that I can ask for further information if needed. _____initial

I authorize Dr. Lane, Dr. Jackson and MABNR to send a report of his findings to any and all other health care providers/ institutions as requested. _____initial

Practitioners Name: _____

Discipline: _____ Phone Number: _____

Our primary relationship is with you, the patient, not the insurance company. Given that we accept your case, our recommendations will be based upon what your needs are & what we believe is in your best interest.

I understand and agree to the following:

There is no guarantee that my health insurance plan or policy will pay for all or part of my care. As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered at Mid-Atlantic Brain and Neurological Rehabilitation, Inc.

Patient signature (*or guardian's signature*)_____Date:_____