MAKAI MOBILE REHAB

Patient Registration

Phone (808) 783-9320 Fax (808) 396-5581

Name:

_____
(Last) (First) (M.I.)

Date of Birth: ___/____/_____ Male / Female

Doctor:_____

Patient Address:

_____
(Street) (Apt #)

_____
(City) (State) (Zip Code)

Social Security:_____
Home Phone:_____
Cell Phone:_____

Occupation:_____
Employer:_____

Emergency Contact Information
Name:_____
Relationship:_____
Address:_____
_____
_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____

Billing Information (same as above)

Name on the account:

_____
Relationship:_____
Address:_____
_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____

Insurance Information

Primary Medical Insurance Company:

_____
SubscriberName:_____
Policy#:_____
Coverage code:_____
Subscriber's Date of Birth:___/___/_____
Secondary Medical Insurance Company:

_____

Assignment of Benefits

I hereby authorize assignment of my medical insurance benefits and/or my Medicare benefits to Makai Mobile Rehab, LLC for application to the bill for services furnished to me by that practitioner. I further authorize Makai Mobile Rehab, LLC to receive direct payment of all such benefit payments. I agree to remain responsible and liable for payments of all amounts due to Makai Mobile Rehab, LLC and not received from my insurance carrier(s). I SHALL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

Signed:_____**Date:**_____

I hereby authorize the release of medical information requested for completion of medical claim form of the above mentioned insurance companies covering services rendered to the patient.

Signed:_____**Date:**_____

No Show / Late Cancellation Policy

A $25 fee for a 'no show' or 'late cancellation' the day of a scheduled appointment can be administered upon the provider's discretion.

Signed:_____**Date:**_____