CHEAR
Center for Health Enhancement and Rehabilitation, Inc.

Last Name_____ First _____ M.I._____

Address_____ Apt. # _____

City_____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Is it OK to call and identify ourselves as the *Center for Health Enhancement and Rehabilitation?* *Yes* _____ *No* _____

When leaving a message, would you like CHEAR to leave a coded message? Yes_____ No_____

SS# _____ & Driver's Licence #_____

Email Address _____

Date of Birth _____ Marital Status _____

**IN CASE OF EMERGENCY PLEASE CALL:** (Name, Home Ph.#, Cell #, relationship)

_____

_____

**Referring Doctor**_____ **Doctor's Phone #** _____

Date of Injury_____

Diagnosis _____

Is this a work related injury? Yes_____ No _____

Is this an auto accident related injury? Yes_____ No _____

Is there an attorney involved? Yes_____ No _____

**PATIENT WORK INFORMATION**

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip Code _____

Work Phone # _____ Ext. _____ Employee I.D. # _____

Occupation _____

**MEDICARE INFORMATION:** Medicare # (if applicable) _____

**PRIVATE INSURANCE INFORMATION**

Insurance Company Name _____ Policy # _____

Group # _____ Certificate # _____ Phone #_____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Is this your coverage? Yes _____ No ____ If no, whose name is on policy? _____

Your relationship to the insured? _____

**SECONDARY INSURANCE INFORMATION:**

Name of Insured _____ Relationship _____

Insurance Policy # _____ Group # _____

Insurance Company Name _____ Phone # _____

Ins. Co. Address _____

City _____ State _____ Zip Code _____

**AUTO INSURANCE INFORMATION:**

Name of Insured _____ Relationship _____

Insurance Policy # _____ Group # _____

Insurance Company Name_____ Phone #_____

Adjustor's Name _____ Phone # _____

Ins. Co. Address _____

**WORKER'S COMPENSATION INFORMATION:**

W/C Insurance Co. _____ Phone # _____

Address _____ City _____ State _____ Zip Code _____

Date of Injury _____ Body Part _____

Adjustor's Name _____ Phone # _____

Claim # _____ Auth. Visits _____ Frequency _____ Duration _____

Employer's Name (at the time of injury) _____ Phone # _____

**ATTORNEY INFORMATION:**

Name _____ Phone # _____

Address _____

City _____ State _____ Zip Code _____

**Authorization to Pay CENTER FOR HEALTH ENHANCEMENT AND REHABILITATION**

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to CENTER FOR HEALTH ENHANCEMENT AND REHABILITATION (CHEAR) and I understand that I am financially responsible for non-covered services and any amount not paid by my insurance. I understand that CHEAR is not a provider for MEDI-CAL services. I also authorize CHEAR to release any information to process this claim.

**SIGNED:** _____ **DATE:** _____