Austin Rehab of Union
Patient Information Sheet

Date_____
Last Name_____ First Name_____ Middle Initial____
Mailing Address: _____City_____ Zip_____
Social Security #_____ Sex: M/F Birth date_____
Home Phone #_____Cell Phone#_____E-mail_____
Marital Status_____ Student: N/A Full Time Part Time
Employer Name_____ Employment: Full time Part time N/A
Employer Phone number_____

Insurance Information
Medicare Medicare Managed Workers' Comp Private Self Pay Tricare Other_____
Is insurance in someone else's name: Y/N If yes, name of insured_____

Accident
Is this condition the result of an accident? Yes/No ___Automobile ___ Work ___Home ___Other

Emergency Contact
Name_____ Relationship_____ Phone #_____

Privacy Practice
Austin Rehab of Union maintains compliance with the Health Information Portability and Accountability Act of 1996 (HIPPA) privacy regulations passed into law on December 20. 2000. We obtain your voluntary consent to provide treatment, release medical records\s to the appropriate entities and those who you designate to provide health care treatment, payment and daily operations of the facility. A written copy of this policy is available upon request.

Please list any person/persons you allow for ARU to give your medical information.
Name(s)_____

Our clinical and office staff uses patient information to ensure quality care and appropriate billing services. You may correct, amend, access and request a copy of your medical record and access history by signing a letter for release of your medical record. The cost for copies medical records is in accordance with state law. We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our business office manager at 864-429-3003.

ARU reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations and guidelines. Thank you for using our facility.

I authorize the release of any medical or other information necessary to process insurance claims and authorize the payment of medical benefits directly to this practice for services rendered.

Signed_____ Date_____