Patient Intake and Consent Form

First Name:_____ MI_____ Date of Injury/Onset_____

Last Name_____ Date of Birth_____ Age_____

Nick Name_____ Height_____ Weight _____

Address_____ Sex:__ M____F Maritial Status: S M D W

City_____ State_____ Zip_____ Emergency Contact Name_____

Home Phone_____ Emergency Contact #_____

Work Phone_____ Accident Related: YES NO

Cell Phone_____ _____ If Accident AUTO WORK OTHER

Email Address:_____ Nature of Accident_____

SS#_____ Employer_____

Policy Holders Name_____ Relationship _____Date of Birth_____

Primary Insurance _____Secondary Insurance _____
(Please Fax Copy of Insurance Card and Drivers License Front & Back)

Are you receiving or have you received home health services: YES NO
Are you receiving or have you received other therapy services: YES NO
Please Initial

CONSENT TO TREATMENT: _____
CONSENT TO TREAT MINOR: _____
AUTHORIZATION OF PAYMENT: _____

I HEREBY ASSIGN ALL BENEFITS DIRECTLY TO SPINE AND REHAB SOLUTIONS AND AUTHORIZE RELEASE OF ANY MEDICAL RECORDS NECESSARY TO FACILITATE MY TREATMENT TO PROCESS MEDICAL CLAIMS AND AS OTHERWISE PERMITTED OR REQUIRED IN THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND FULLY THAT IN THE EVENT MY INSURANCE COMPANY OR FINANCIALLY RESPONSIBLE PARTY DOES NOT PAY FOPR THE SERVICES I RECEIVE**, I WILL BE FINANCIALLY RESPONSIBLE FOR PAYMENT._____**

NOTICE OF PRIVACY_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____Date:_____