Patient Intake and Consent Form

First Name_____ MI_____ Last Name_____

Nick Name_____ Date of Birth_____/_____/_____ Age_____

SSN#_____ Sex ____ M____F Marital Status: S M D W

Home Phone_____ Cell_____ Work Phone_____

Email Address _____ Would you like to receive emails about appointments and account updates? ____ Yes ___ No

Address_____

City_____ State_____ Zip_____ Employed Yes No Retired

Employer _____

Emergency Contact Name/Relationship_____ Emergency Contact #_____

Date of Injury/Onset_____ Accident Related: YES NO If Accident AUTO WORK OTHER

Nature of Accident_____

Primary Insurance _____ Workers Comp Yes No

Policy Holder Name_____ Date of Birth _____/_____/_____

Relationship to Policy Holder_____ Secondary Insurance _____

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 FOR THE SERVICES I RECEIVE**, I WILL BE FINANCIALLY RESPONSIBLE FOR PAYMENT. _____**

NOTICE OF PRIVACY_____

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

Patient/Guardian Signature_____Date:_____