Rebound Rehabilitative Services

105 Southpark Blvd, Suite B201 • St. Augustine, FL 32086 • (904) 824-1636

Please complete each section (N/A if not applicable)

Full Legal Name: _____ (e.g. John M. Smith, Sr.) Soc. Sec. # _____-___-_____

How would like to be addressed ? _____ (e.g. John, Mr. Smith, Dr. Smith, Professor)

Date of Birth: _____/_____/_____ Age: ____ Sex: M / F Marital Status: _____

Local Street Address: _____

City: _____ State: _____ Zip: _____

How long have you lived there? _____ Spouse/Caregivers name? _____

Home Phone #: _____ Cell/Mobile # _____ Email: _____

Permanent address (if different from above) or previous address (if less than 2 years at above address)

Street Address: _____+_____

City: _____ State: _____ Zip: _____

Alternate Phone #: _____ School Name _____

Employer _____ Occupation & Department: _____

Work Phone #: _____ Extn: _____ Best time to call: _____

Name of nearest relative not living with you: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Family Physician: _____ Phone #: _____

Which Pharmacy do you use ? _____ Location: _____ Phone #: _____

How did you hear about Rebound? _____

Were you injured as a result of an accident? Yes _____ No _____ **If yes, please ask to complete our accident form.**

POLICIES AND PROCEDURES FOR TREATMENT

I consent to physical therapy treatment as ordered by my physician.

I agree to be financially responsible for all medical charges and services rendered to myself, or my child, whether or not covered by insurance. I agree to any cost of collection including attorney's fees, court costs and legal interest, which may be incurred in enforcing this obligation. This will represent 50% of any outstanding balance.

I authorize the release of any medical information necessary to process insurance benefits to Rebound Rehabilitative Services. I authorize any reports, X-rays or MRI's, regarding my treatment, to be released to Rebound Rehabilitative Services. I authorize payment of medical benefits to Rebound Rehabilitative Services. In the event that I obtain legal representation regarding this case, I hereby authorize my attorney to protect any outstanding balance owed to Rebound Rehabilitative Services. This will remain in effect until revoked by me in writing.

_____ _____ _____

Signature of Patient or Patient's Representative Relationship to Patient Date