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

Who Referred you to Rebound? ___________________ (e.g. Friend, Family, MD, Google, Physician, Workshop)

Name: Last ___________________ First _____________________ Middle: ___________________________

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

Date of Birth: ___/____/____ Soc. Sec. # _____- ___ -______ Age: _____ Sex: M / F

Address: ____ Apt/Suite # _________

City: ____________________State: ______ Zip: ______________ Home Phone # ________________________

Cell/Mobile # _________________ Best time to call: ___________ Email: ________________________________

Marital Status: ______________ Spouse name: _________________________ Phone # _____________________

Name of nearest relative not living with you: _______________________ Phone #: _________________________

Employer: ____________________________________ Address: _______________________________________

City: ______________State: _______ Zip: _________ Work Phone #: ____________________ Ext: ___________

Occupation: ___________________________ Supervisor Name: _______________________________________

Referring Physician: ____ Phone #: _________________________

Family Physician: ____ Phone #: _________________________

Were you involved in Auto Accident? YES/ NO Date of accident: _____/_____/______ State of accident ___________

Were you injured on the job/work? YES / NO Date of injury ____/____/______

Primary Insurance Carrier ____________________________ Insured _______________________________________

ID# ____________________________ Group # ______________________ Phone # ________________________

Secondary Insurance Carrier __________________________ Insured _______________________________

ID# ____________________________ Group # ______________________ Phone # ________________________

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

St.Augustine Office: 105, Southpark Blvd., Suite B 201, St.Augustine, FL 32086 Ph: 904-824-1636, F: 904-824-7488
Jacksonville Office: 644 Cesery Blvd, Suite 200, Jacksonville, FL 32211 Ph: 904-903-2755, F: 904-903-2756
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