Patient Name: ______________________ **SS#:** ______________
Address: ______________________ **DOB:** ______________
City, State, Zip: ______________________ Marital Status: S M W D
Email Address: ______________________ Sex: M F
Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________
Emergency Contact Name/Phone Number: ______________________ Relationship: ____________
Patient Employer: ______________________

Referred by:
Primary Physician: ______________ Referring Physician: ______________
Self Referral Yes/No Date last seen by Physician: ______________
Why did you choose Rebound? ______________________

Insurance: (Please provide primary card holder information below. DOB is required for billing purposes. We will make a copy of your insurance cards/drivers license for our record.)
Primary Insurance: ______________________
Primary Holder Name: ______________ DOB: ________ Relationship: ________
Secondary Insurance: ______________________
Primary Holder Name: ______________ DOB: ________ Relationship: ________
Other Insurance: ______________________
Insurance Holder Name: ______________ DOB: ________ Relationship: ________

Who is responsible for payment? Name: ____________ Contact Number: ____________

Accident Information:
Is the injury caused from an accident: Yes/ No Date of Accident: ____/____/____
Provide a brief description of **where** accident occurred (car, work etc.) and **what** happened?

____
____
____

Claim Number: ____________ Contact Name: ____________ Phone: ____________

By my signature, I am authorizing that: I am giving consent for treatment by Rebound Physical Therapy; I understand that a Physical Therapy diagnosis is not a medical diagnosis by a physician; I am authorizing direct assignment of my rights and benefits for insurance payment to be directed to Rebound Physical Therapy for any professional services rendered; I understand that verification of insurance does not guarantee payment and that I am accepting responsibility for payment of all services received; I understand that policies related to insurance are between the insurance carrier and myself; and I take responsibility for any costs or fees associated by my failure not to pay for services provided in a timely manner. Should my account default to an outside collection agency, I understand that I am responsible for all reasonable and customary fees associated with collection of the debt.

Patient/Representative Signature: ______________________ **Date:** ____________