Patient Summary

Patient Information:

Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____State: _____ Zip: _____

Phone: Home:_____ Cell: _____ Work:_____

Patient Height: _____ Patient Weight: _____

Emergency Contact: _____ Phone: _____

Email Address:_____

Medical Information:

Referring Physician: _____ Diagnosis: _____

Date of onset: _____ Description of problem: _____

Have you had surgery? Y___ N ___ If yes, date of surgery: _____ Surgeon: _____

Insurance Information:

Who is responsible for the account?

Name: _____DOB: ____/____/_____ Relationship to patient:_____

Address: _____

City: _____ State:_____ Zip: _____

Insurance Company: _____ Insurance Phone: _____

SSN: _____ Insurance ID: _____ Group #: _____
If Medicare: provide 2^{o} insurance:_____ id:_____ phone:_____

I certify that the above information provided by me is true and correct to the best of my knowledge.

_____ _____ _____

Signature **Date**

Assignment of Benefits: I hereby assign payment directly to **Rebound Therapy and Wellness Clinic, LLC,** who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any cost incurred regarding collection of payment for services rendered.

_____ _____ _____

Signature **Date**