



Patient Information

Name: _____ Date of Birth: ____ / ____ / ____ Marital Status: **M S D W**
Gender: **M F** E-Mail Address: _____, if none Fax #: _____
Social Security #: _____ Driver's License#: _____ State _____
Address: _____ City _____ State _____ Zip _____
Phone#: _____ Work: _____ Alternate: _____
Employment Status: Employed Student Retired Unemployed Disabled (unable to work)
Employer: _____ Occupation: _____
Was this injury/symptom accident related? **NO YES**➤ **If yes:** Date of Accident: _____
Place of Accident: **Automobile** **Work** **Home** **Other:** _____
Who is responsible for this bill? _____ SSN: _____
Next of Kin: _____ Phone Number: _____
Who may we thank for referring you to us? _____ Phone: _____

ASSIGNMENT OF BENEFITS/CONSENT TO TREATMENT

I hereby understand and fully agree that (regardless of my insurance status), I am ultimately responsible for any balance owed to Downtown SportFit Rehab and Training (Lisa Kearns, RPT) for any medical services rendered to me, including any unfulfilled deductible amount and/or co-insurance on my insurance plan. I also understand that any balance not paid after 30 days will be charged finance charges as allowed per state laws (% subject to change). Furthermore, I also understand that should my account be transferred to a collections agency or attorney for further collective action, I will be responsible for the principle amount and any collection fees, if any. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I do hereby consent to such treatment by the authorized personnel of Downtown SportFit Rehab and Training. This consent is intended as a waiver of liability for such treatment except for acts of negligence.

If patient is a minor, a parent must sign this form and consent to treatment. Otherwise, services can not be rendered per State Laws. I have read and understood all of the above and I certify that this information is true and correct to the best of my knowledge. Also, I will notify Downtown SportFit Rehab and Training if any of the above information changes during the course of my treatment.

Patient's Name:

Patient's Signature:

Date Signed:

Parent's Name (if patient is a minor):

Parent's Signature (if patient is a minor):

Date Signed:

Therapist:

Therapist Signature:

Date Signed: