☐ Biltmore ☐ Paradise

SELF-PAY PATIENT INFORMATION:

Patient's Name _____ Date of Birth ___/___/___ Social Security Number ___-___-___

Driver's License Number _____ State of Issuance _____

Home Address _____ City _____ Zip _____

Home Phone Number (___)_____ Work Phone Number (___)_____ Alternate Phone Number (___)_____

Employer _____ Occupation _____

Who may we thank for referring you to us? _____ Phone Number: (___)_____

Next of Kin _____ Phone Number: (___)_____

Assignment of Benefits:

I understand that I am ultimately responsible for any balance owed to SportFit Rehab and Training for any medical services rendered to me. All services must be paid by the end of the week that services were rendered. I also understand that any balance not paid after 30 days, will be charged finance charges applicable to state law (% Subject to change). Furthermore, I also understand that should my account be transferred to a collections agency or attorney for further action, I will also be responsible for the fees incurred, if any.

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 SportFit Rehab and Training if any of the above information changes during the course of my treatment.

I was fully advised of my payment requirements, which is $_____ per visit for an hour treatment by _____ of SportFit Rehab and Training on ___/___/___ and agree to assume this financial responsibility/agreement.

Patient's Name _____ Signature _____ Date _____

Therapist Signature _____ Patient Evaluated by: _____ Will be treated by: _____