Rebound
Sports and Orthopedic Physical Therapy, LLC

First:_____ **Middle Initial**_____ **Last:** _____
Patient Mailing Address:_____
City:_____ **State:**_____ **Zip:**_____ **Date of Birth**_____/_____/_____
Social Security #:_____-_____-_____ **Patient Hm Phone:** _____ **Cell #:**_____
Email : _____ **Gender: Male** ☐ **Female** ☐
Marital Status: Single ☐ **Married** ☐ **Other** ☐ **Spouse's Name (if applicable):**_____
Emergency Contact:_____ **Relationship:**_____ **Phone:**_____
Patient's Current Employer:_____ **Phone:**_____
Referring Physician:_____ **Office Name:**_____
How did you hear about us? (check one) Physician ☐ **Friend** ☐ **Other**_____

WORK COMP OR AUTO ACCIDENT INFORMATION

Insurance Company:_____ **Claim #:**_____
Adjuster's Name:_____ **Phone:**_____
Date of Injury:_____/_____/_____
If work comp, provide the name of your employer at time of injury:_____
If auto accident, provide the street/intersection where the accident occurred:_____

CONSENT FOR CARE

I understand that I am responsible for all fees regardless of insurance coverage. I am responsible for furnishing all insurance information correctly prior to treatment unless other arrangements have been made in advance. I authorize Rebound Sports and Orthopedic Physical Therapy, LLC to examine me, administer treatment as necessary and perform procedures that are considered therapeutically or diagnostically necessary.

BILLING POLICY

I understand that it is my responsibility to provide Rebound Sports & Orthopedic Physical Therapy with current, accurate billing information at the time of check-in and to notify Rebound of any changes in this information.

I understand that it is my responsibility to know my co-pay and/or co-insurance benefits prior to services being rendered. I understand that my insurance plan benefit booklet and/or a representative from my insurance carrier can assist me in obtaining this information if Rebound is unable to verify benefits prior to treatment.

I understand that if I present an insufficient funds (NSF) check for payment on my account, I will be charged a $25 NSF fee.

I understand that I will be billed for any amount due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment after the second statement, that my account will be flagged for Collection Review and sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

My signature below confirms that I have read and agree with the consent for care and the billing policy and understand my financial obligation as it pertains to Rebound Sports & Orthopedic Physical Therapy, LLC.

Signature_____ **Date**_____