



**Dedicated
to
Quality
Care**

REHABILITATION SERVICES

- Physical Therapy
- Occupational Therapy
- Aquatic Therapy
- Physical Reconditioning
- Industrial Rehabilitation
- Transitional Work
- Sports Rehab/Athletic Training
- Wellness Programs
- Back Education/School
- Pediatrics/Geriatrics
- Massotherapy
- Spinal Decompression Therapy
- Laser Therapy

ANCILLARY STAFF

- RN/Cert Case Manager
- Cert Transitional Case Developer
- Registered Dietician
- Massotherapist

Rehab Unlimited at Southbridge

Name: _____ Age: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home: _____
 Cell Phone: _____
 Work: _____
 Email Address: _____
 Emergency Contact: _____ Phone: _____
 Date of Birth: _____ Marital Status: _____
 Social Security #: _____
 Employer: _____ Job: _____
 Referring Physician: _____
 Primary Health Insurance: _____
 Secondary Health Insurance: _____

CONSENT FOR TREATMENT

I hereby consent to Physical or Occupational Therapy treatment as prescribed by my Physician.

Signature

Date

AUTHORIZATION

I authorize Rehab Unlimited at Southbridge to bill for services to my insurance carrier. I understand that my insurance or combination of insurances, may only recognize, accept or pay a portion of the total amount which I will then owe or shall owe and be personally responsible for the balance on my account. Should the account be referred to a collection agency, I shall be responsible for the fees and collection expense. (all delinquent accounts bear the interest of the prime rate charged by Sky Bank which is in effect at the time the charges are incurred).

Signature

Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I have reviewed and understand Rehab Unlimited's notice of protected health information practices. I understand and consent to the uses and disclosures of my health information according to the articles outlined in the notice of protected health information practices.

Signature

Date