Back-in-Action
REHABILITATION, S.C.

Patient Name:
DOB:
Acct #:
Date:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
ASSIGNMENT OF BENEFITS

I hereby authorize Back-in-Action Rehabilitation to provide treatment, release information pertaining to my treatment for and insurance purposes: and/or receive direct insurance payments otherwise payable to me for services rendered. I understand that I am financially responsible for payment of all services; including those charges not covered by my insurance. I also acknowledge I have received and had a full opportunity to read and consider the contents of the Privacy Notice. I understand that, by signing this form, I am confirming my written permission for the discloser of my protected health information, as described in this form.

Signature_____ Date_____

Other than your doctor, how did you hear about us? (Check all that apply)

Newspaper

- ☐ Action Advertiser
- ☐ The Reporter
- ☐ Tri-County News
- ☐ Chilton Times
- ☐ Statesman
- ☐ Other Newspaper
- ☐ Phonebook

Radio

- ☐ KFIZ 107
- ☐ WFDL 97
- ☐ WTCX 96
- ☐ WMDC 98.7
- ☐ Other Radio Station

Other

- ☐ Billboard
- ☐ Building Sign
- ☐ Drove by
- ☐ Back in Action Website
- ☐ Other

_____

☐ If you heard about us through a friend or relative, may we have their name so we may thank them?

_____

EMERGENCY CONTACT INFORMATION

Name:_____

Relationship:_____

Phone #:_____ ☐ Work ☐ Home

Alternate Phone #:_____ ☐ Work ☐ Home