



Name: \_\_\_\_\_

Sex: \_\_\_\_\_ M \_\_\_\_\_ F

Street: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_

SS #: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Primary M.D.: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Injury Area: \_\_\_\_\_

Referring M.D.: \_\_\_\_\_  
(If Applicable)

Date of Injury: \_\_\_\_\_

Email : \_\_\_\_\_

Have you been to another facility this year for occupational or physical therapy for your current condition? YES \_\_\_\_\_ NO \_\_\_\_\_

Is this injury due to an auto accident or work related injury? \_\_\_\_\_

It is the policy of this practice that fees/charges are due at and payable at the time of each visit. By signing below I agree to be financially responsible for all bills incurred while receiving care at DMC Athletics and Rehabilitation, Inc. and guarantee payment of all unpaid balances for services rendered to me or my family members. I also agree to pay interest on any and all outstanding balances due at a rate of 1.5% per month (18% per annum). I agree to pay for all collection fees not to exceed 50% of the outstanding debt. By signing below I acknowledge the acceptance of the 'notice of privacy policies', however I am authorizing the release of medical records/information for insurance purposes to my insurance company, their agents, and referring doctors.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_