PATIENT INFORMATION

Name _____ Date of Birth_____
(First) (Last)

Address _____ Apt # _____

City _____ State_____ Zip _____

Home Phone _____ Cell Phone_____

Email _____ Marital Status M❑ S❑ W❑ Sex M❑ F❑

How did you hear about us? Former Patient ❑ Physician ❑ Search Engine ❑ Other❑
Specify _____

EMPLOYMENT INFORMATION

Employer_____ _____ Occupation _____

Address _____

City _____ State _____ Zip_____

ADDITIONAL INFORMATION

Referring Physician _____ Phone _____

Address _____

City _____ State _____ Zip_____

Date of Injury/Illness _____ Auto accident? Y ❑ N ❑

Is this an approved Workers Compensation Injury? Y ❑ N ❑ Lawsuit? Y ❑ N ❑

INSURANCE INFORMATION

We will make a copy of your insurance cards.

PATIENT INFORMATION RELEASE OF AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize Sovereign Rehabilitation of IL, LLC to release to my healthcare team and/or my insurance company (s) any information required for the purposes of healthcare management and/or for processing all medical claims on my behalf.

I hereby assign all medical benefits to which I am entitled to Sovereign Rehabilitation in the event that they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable cost associated with the collection of this debt, including but not limited to, collection service fees, attorney's fees and all court costs and additional fees associated with the recovery of this debt. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Sovereign Rehabilitation as may be directed by prudent medical practice by illness, injury or condition. This consent is intended as a waiver of liability for such treatment expecting acts of negligence.

_____ _____

Authorized Signature Date