North Shore
SPINAL & SPORTS REHABILITATION
Setting the standard for rehabilitation since 1988

PATIENT NAME: MR./MRS./MS _____

SSN: _____ BIRTH DATE: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____ WORK PHONE #: _____

EMAIL ADDRESS: _____

EMPLOYER NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

List Your Referring & Primary Doctor and Any Other Doctor You Want Your Report Sent to

WHO IS YOUR REFERRING DOCTOR: _____ PHONE #: _____

WHO IS YOUR PRIMARY DOCTOR: _____ PHONE #: _____

DOCTOR: _____ PHONE #: _____

DOCTOR: _____ PHONE #: _____

If This is a Work Comp Case or Auto Accident and You Have a Personal Injury Attorney, List Below

PERSONAL INJURY ATTORNEY: _____ PHONE #: _____

Primary Insurance Card Holder Information

GUARANTOR NAME: MR./MRS./MS _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SSN: _____ BIRTH DATE: _____ PHONE #: _____ WORK #: _____

EMPLOYER NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Informed Consent for Treatment

COMPLETE IF THE PATIENT IS OVER THE AGE OF 18 YEARS OF AGE OR AN EMANCIPATED MINOR:

The undersigned being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the consent and release, do hereby represent that I, _____ (patient), consent to receive rehabilitation treatment from North Shore Spinal and Sports Rehabilitation.

COMPLETE IF THE PATIENT IS A MINOR OR WHEN AN ADULT PATIENT IS NOT COMPETENT TO SIGN:

In the treatment of _____ (patient), I _____, the patient's representative, consent that this patient can receive rehabilitation treatment from North Shore Spinal and Sports Rehabilitation.

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and consent for treatment.

Patient or Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____