Center for Pain Management & Rehab

Patient Name_____

Date of Birth_____ SSN _____

Address _____ City_____ Zip_____

Telephone_____ Alternate Telephone_____

Email Address_____

Consent to receive informational newsletters via email: Yes_____ No_____

Spouse's Name_____ Date of Birth_____

Employer_____

Primary Insurance_____ Secondary Insurance_____

Pharmacy_____

Emergency Contact_____Phone _____

I hereby assign, transfer and set over Center for Pain Management and Rehabilitation all of my rights, title and interest to my medical reimbursement benefit under my insurance policy. I authorize any release of medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. **I understand that I am financially responsible for all charges whether or not they are covered by my health insurance.**

Patient Signature_____ Date_____