Pt. Name: _____ Date of Birth: _____

Please list all medications, vitamins and nutritional supplements that you are currently taking:

Medication/Vitamin/Supplement	Dosage	Reason for Taking

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health.

I certify that I, or my dependent(s), have insurance coverage with _____ and assign directly to Advanced Rehab and Medical all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all submissions.

The above-named doctor may use my health care information to above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient or Guardian Date