

Other than your doctor, how did you hear about us? (Check all that apply)

<p><b>Newspaper</b></p> <p><input type="checkbox"/> Action Advertiser</p> <p><input type="checkbox"/> The Reporter</p> <p><input type="checkbox"/> Tri-County News</p> <p><input type="checkbox"/> Chilton Times</p> <p><input type="checkbox"/> Statesman</p> <p><input type="checkbox"/> Other Newspaper</p> <p><input type="checkbox"/> Phonebook</p>	<p><b>Radio</b></p> <p><input type="checkbox"/> KFIZ 107</p> <p><input type="checkbox"/> WFDL 97</p> <p><input type="checkbox"/> WTCX 96</p> <p><input type="checkbox"/> WMDC 98.7</p> <p><input type="checkbox"/> Other Radio Station</p>	<p><b>Other</b></p> <p><input type="checkbox"/> Billboard</p> <p><input type="checkbox"/> Building Sign</p> <p><input type="checkbox"/> Drove by</p> <p><input type="checkbox"/> Other</p> <p>_____</p> <p>_____</p>
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If you heard about us through a friend or relative, may we have their name so we may thank them?

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**EMERGENCY INFORMATION**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship: \_\_\_\_\_ Work # \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION  
ASSIGNMENT OF BENEFITS**

I hereby authorize Back-in-Action Rehabilitation to provide treatment, release information pertaining to my treatment for and insurance purposes: and/or receive direct insurance payments otherwise payable to me for services rendered. I understand that I am financially responsible for payment of all services; including those charges not covered by my insurance. I also acknowledge I have received and had a full opportunity to read and consider the contents of the Privacy Notice. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_