Marina

Rehabilitation & Health Services

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**INSURANCE, TREATMENT AUTHORIZATION, ASSIGNMENT AND RELEASE FORM**

Patient’s Name S.S. #

Last First M.I.

Address City , MI ZIP

Home Ph. # Alternate Ph. #

Date of Birth Sex: M F Marital Status: S M D W Sep.

Email Address (mandatory)

Person to Reach in Case of Emergency

Last First M.I.

Relation to You Emergency Ph. # Alternate Ph. #

Emergency Address City , MI ZIP

Patient Employer Occupation

Employer Address Work Ph. #

Spouse Employer Work Ph. #

Work Comp. Case? Y N Date of Injury Insurance

Auto Accident? Y N Date of Injury Insurance

1st Insurance Company

Contract # Group # Subscriber Relation

2nd Insurance Company

Contract # Group # Subscriber Relation

Contract # Group # Subscriber Relation

My signature on this form gives permission for Marina Rehabilitation and Health Services to release this information on this sheet or any information regarding my condition, results of tests and treatment given to me, to my attending/referring physician, insurance carrier, attorney, Work Comp. Rep., Insurance Rep., or social administration and/or Medicare program or its carriers, or to any outside testing facilities. In the event health insurance, Auto or Work Comp in any way limits, alters, cancels, denies or modifies my level of coverage - I am solely responsible to Marina for payment in full of these charges. It is also giving us permission to contact you on different occasions.

Patient Signature Date

Witness Signature Date