ADVANCED SPINE PHYSICAL THERAPY

PATIENT INFORMATION FORM / CONSENT TO TREAT 2021

Last name: _____ First: _____ M.I. _____

Address: _____City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security #: _____ Sex: M / F

Tel: Home: _____ Cell: _____ Work: _____

Preferred Tel # to leave detailed information regarding my medical care: Home / Work / Cell

Would you like appointment reminders via email or text: **EMAIL** Yes☐ No☐ **TEXT** Yes☐ No☐

Email: _____

Emergency Contact: _____ Tel: _____

I give my permission to release all of my medical – related information to the following person:

Name:_____ Tel: _____

IS YOUR CONDITION DUE TO A WORK ACCIDENT? Yes ☐ No☐ Date of Injury: _____

IS YOUR CONDITION DUE TO A CAR ACCIDENT? Yes ☐ No☐ Date of Injury: _____

Insurance Company: _____ Claim#: _____

Adjuster's Name & Contact Number: _____

Privacy Notice: We at Advanced Spine Physical Therapy feel that your privacy should be protected. In the course of your treatment, we collect personal information about you that is necessary for treating you. As our valued patient, we treat this information as confidential & recognize the importance of protecting it. A copy of our complete HIPPA Notice of Privacy Practices is available upon request. By signing below, I acknowledge that I have been permitted to access &/or have a copy of this information.

Consent to Treat: I hereby consent to such treatment procedures & patient care which, in the judgment of my therapist &/or physician, may be considered necessary or advisable while a patient at Advanced Spine Physical Therapy.

PRINT NAME:_____ **DATE:** _____

SIGNATURE OF PATIENT OR GUARDIAN: _____