Patient Information

Last Name _____ First Name _____ Date of Birth _____

SSN _____ Sex: M / F Email _____

Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Please send my appointment reminders through: TEXT(CELL) CALL(CELL) CALL(HOME) EMAIL

Emergency Contact _____ Phone _____ Relationship _____

Referring Physician _____ Practice Name _____ Phone _____

Did a friend/family member tell you about us? Full Name: _____ Phone _____

☐ **CHECK THIS BOX IF THIS INJURY IS RELATED TO A MOTOR VEHICLE ACCIDENT**

If patient is a minor, AUTHORIZATION AND CONSENT TO TREAT BELOW:
The undersigned below does hereby authorize Chandler Physical Therapy & Sports Rehab consent to examine and treat the above mentioned minor by employees of Chandler Physical Therapy & Sports Rehab without a Parent or Guardian present.
Mother/Father/Guardian _____ (signature)

Designated Individuals Authorization - Fill this out if you grant permission to other individuals to make or change appointments or inquire about billing/treatment.

Authorized Designees:

Name _____ Relationship _____

I have read or been offered a copy of the Patient Responsibility & Attendance Policy and it is my understanding that I am financially responsible to Chandler Physical Therapy & Sports Rehab, LLC for providing rehabilitative services to me, or the above named patient. I authorized my insurer to pay any benefits directly to Chandler Physical Therapy & Sports Rehab, LLC. I agree to pay Chandler Physical Therapy & Sports Rehab, LLC the full and entire amount of all charges incurred by the above named patient, or me or any portion not covered by my insurance carrier.

I have read or been offered a copy of Chandler Physical Therapy & Sports Rehab, LLC's Notice of Information Practices. I understand that Chandler Physical Therapy & Sports Rehab, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Chandler Physical Therapy & Sports Rehab. LCC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Chandler Physical Therapy & Sports Rehab, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I authorize the therapists of Chandler Physical Therapy & Sports Rehab, LLC to administer such treatment as prescribed and considered therapeutically necessary on the basis of findings during the course of treatment.

Patient/Legal Guardian Signature _____ Date _____