Total Care
physical therapy, p.c.

PATIENT INFORMATION RELEASE

(Please complete entirely)

Patient Name:_____ Date of Birth:_____

It is very important that we have accurate information in which to contact you should we need to move or cancel your appointment in the case of an emergency.

CONTACT INFORMATION: I wish to be contacted in the following manner:

Home Telephone: _____

- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with call back number only

Work Number:_____

- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with call back number only

Cell Phone Number: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

What is the best number to reach you on?

☐ Home ☐ Work ☐ Cell

Emergency Contact:_____
Name Phone Number Relation

Emergency Contact:_____
Name Phone Number Relation

EMAIL ADDRESS:_____

We occasionally contact patients via email to update them on upcoming events exclusively offered to our patients... i.e. newsletter, health tips, events, contests and prizes. Your address will not be shared or sold to any third parties and you will not receive large amounts of messages. We only wish to keep our patients informed and offer them opportunities to improve their health.

☐ O.K. to send me information via email ☐ Please do not send me any email

HOW DID YOU HEAR ABOUT: Please ☑ the appropriate box that best describes how you **first** heard of Total Care Physical Therapy

- ☐ Community event or lecture
- ☐ Doctor referred you
- ☐ Drove by our office
- ☐ Email received from us
- ☐ Friend/family...who?_____
- ☐ Internet search
- ☐ Mailing
- ☐ Phone book
- ☐ Radio/TV advertisement
- ☐ Sign...where?_____
- ☐ Facebook
- ☐ LinkedIn
- ☐ Twitter
- ☐ WordPress
- ☐ Other_____

NOTICE OF PRIVACY PRACTICES: Acknowledgement Of Receipt

By signing below, I acknowledge receipt of Total Care Physical Therapy's Notice of Privacy Practices. I acknowledge the disclosure of my Protected Health Information (PHI) is governed by the guidelines established in Notice of Privacy Practices. Any request to change, grant or deny an individual or entity access to the patient's (PHI) must be submitted in writing and will be enforced until revoked by the patient/gaurdian. This practice will verify the identity of any individual or entity requesting (PHI) using patient's date of birth.

Patient/Guardian Signature:_____ Date:_____

Description of Personal Representative's Authority (attach necessary documentation)

_____

FOR OFFICE USE ONLY:

We were unable to obtain a written acknowledgement of Receipt of the Notice of Privacy Practices because:

☐ The individual refused to sign ☐ Other:_____

Employee preparing document: _____ Employee Signature: _____ Date: _____