Patient Information

Today's Date: Last Name: First:

Date of Birth: SS#: Gender:

Street Address:

Home Phone: Work Phone:

Email: (Email used ONLY for appointment verification)

Referring Physician:

Emergency Contact: Name:

Phone: Relationship:

Patient Information Acknowledgment:

I have read and fully understand Foundational Physical Therapy, LLC (Chandler Physical Therapy) notice of patient information practices. I understand that Foundational Physical Therapy, LLC (Chandler Physical Therapy) may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payments, evaluating the quality of service provided, and for any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notice the practice. I also understand that Foundational Physical Therapy, LLC (Chandler Physical Therapy) will consider request for restrictions on a case by case basis, but does not have to agree to requests of restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy, LLC (Chandler Physical Therapy) notice of patient information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at this time.

Patient Initials:_____

Consent to Treatment

I understand I have the right to ask any questions in regards to my individual treatment plan prior to receiving any treatment. By signing this agreement, I hereby give consent to receive treatment from Foundational Physical Therapy, LLC (Chandler Physical Therapy) as prescribed by my physician and/or recommended by my therapist.

Patient Initials:_____

Appointment Cancellation Policy

All patients are required to provide a 24 hour notice to Foundational Physical Therapy, LLC (Chandler Physical Therapy) if you are unable to attend a scheduled appointment. There will be a $25 fee for any no show or cancellation made less than 24 hours before your scheduled visit.

Patient Name: _____

Signature:_____

Date :_____