FOLEY PHYSICAL THERAPY

PATIENT INTAKE

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Preferred Phone Number _____

☐ Home ☐ Mobile

If Mobile, May I Text You? ☐ Yes ☐ No

Email Address _____

Emergency Contact Person _____ Phone _____

Referring or Primary Care Physician _____

How Did You Learn About Foley Physical Therapy? _____

HIPAA Notice of Privacy Practices

I understand that Foley Physical Therapy will make every effort to keep my protected health information confidential and private. I understand that Foley Physical Therapy may use and disclose my protected health information for treatment and for related health care operations. I acknowledge that the Foley Physical Therapy Notice of Privacy Practices was made available to me.

X _____ _____

Patient Signature Date

Consent for Treatment of a Minor Patient

In the event that I am unable to accompany my minor child (under 18 years of age) to his/her Foley Physical Therapy appointments, I permit Foley Physical Therapy to render treatment to my child while I am not present.

X _____ _____

Parent or Guardian Signature Date