BLASER PHYSICAL THERAPY

Patient Name:_____ Date of Birth_____

HIPPA NOTICE

I understand that as part of my healthcare, Blaser Physical Therapy originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care and treatment. Blaser Physical Therapy HIPPA Notice of Privacy Practices is available to you in its entirety in hard copy or on our website, www.blaserphysicaltherapy.com. I acknowledge that I have been offered Blaser Physical Therapy's Notice of Privacy Practices which describes how medical information about you may be used and disclosed. It also explains how you can get access to this information, as well as whom to contact if you feel your privacy rights have been violated.

_____ _____
Patient Signature Date

PREFERRED METHODS OF COMMUNICATION

In an effort to reach you to confirm appointments, leave messages regarding your healthcare, and to discuss insurance and billing issues, we ask that you please complete the following phone contact information. We would like to insure that your medical information is properly protected as required by HIPPA guidelines. By completing the following contact information you are giving us authorization to leave messages with those individuals listed at the numbers provided below.

Please list the names of family or friends with whom you authorize us to speak with relating to your treatment at Blaser Physical Therapy.

1. _____ Relationship_____ Phone_____
2._____ Relationship_____ Phone_____

Please list the telephone numbers where we can reach you:

Home_____ May we leave a message? YES NO
Work_____ May we leave a message? YES NO
Cell _____ May we leave a message? YES NO

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In the event that I become incapacitated (unable to communicate my wishes), including death, I hereby release my medical records to:

Name:_____

_____ _____
Patient Signature Date