LIVERMORE PHYSICAL THERAPY
PATIENT REGISTRATION FORM

Patient Name:______________________________ Sex: M F

Address: ______________________City: ____________ Zip:__________

Phone (H):________________ Cell: ____________Birth Date: ____________

Employer:______________________ Phone (W): ________________

SSN: ____________________Referring Physician: ____________________

Insurance Company:______________________ ID#: ________________

Policy Holder: __________________Birth Date: __________SSN:__________

Relation:____________________ Employer:______________________

Emergency Contact: ____________________Phone: ____________________

Spouse Name: ______________________Phone: ____________________

Email Address:______________________ Whom may we thank? for your Referral:__________

CONSENT FOR TREATMENT: I hereby agree to allow Livermore Physical Therapy to evaluate my medical condition and provide necessary and appropriate treatments. **Initials:**________

If the patient is a minor: I hereby certify that I am the parent or legal guardian of above patient and hereby authorize Livermore Physical Therapy to evaluate their medical condition and provide necessary and appropriate treatments.

SIGNATURE:______________________ **DATE:**______________________

INFORMATION: Many of our patients receive electrotherapy treatments that utilize electrodes reused in the clinic. If you prefer to have electrodes for your use only, we will provide them at a cost of $12.00. It is your responsibility to let the therapist know.

COPY OF RECORDS: You are entitled to a copy of your medical records. The fee for copies is $ 40.00 for us to copy or $20.00 for retrieval fee for a copy service. You must sign an authorization form before records are released.

I certify that the above statements are, to the best of my knowledge, accurate and true.

PATIENT SIGNATURE:______________________ **DATE:**______________