PHYSICAL THERAPY eVOLUTION

Full Name	Date of Birth	Today's Date
Address	City/State	Zip
Phone (mobile)	Phone (home)	Sex (M/F)

Email: (reminders will be sent to this address 24 hours prior to your appointment time)

Would you like to be notified via email of Physical Therapy updates and notifications? Y N

Primary Care Physician	Other Physician/Specialist

Were you Referred? Y N If so, by whom?

Is your condition due to an auto or work-related accident? Y N	Date of Accident
Did you file a claim? Y N	Claim Number
Adjuster's Name and Contact Number	Attorney Name and Contact Number

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Treatment Consent

A licensed Physical Therapist will perform your evaluation and treatments. A variety of treatment techniques may be performed, as allowed under the physical therapist's scope of practice. I hereby consent to Physical Therapy Evolution providing care and treatment for my condition.

HIPAA Privacy Rule Acknowledgement

I acknowledge that I have read the HIPAA Privacy Notice, accessed online at https://www.hhs.gov/sites/default/files/privacysummary.pdf. I understand that I may receive a copy of this notice upon request at any time, and that I may inquire at Physical Therapy Evolution with any questions I may have regarding the Notice of Privacy Practices.

Cancellation and No-Show Policy

If I am unable to keep my appointment, I understand that a 24-hour notice is required (if my appointment is on a Monday, I understand cancellation notice is required on or before the preceding Friday), or I will incur a full appointment charge. We appreciate your understanding of this policy.

_____ _____

Responsible Party Signature Date