WHERE MOVEMENT AND LIFE COME TOGETHER

PHYSICAL THERAPY CLINIC: Patient Registration

Last Name First MI		Date
Physical Address Apt# City State Zip		
Mailing Address Apt# City State Zip		
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )
Contact Preference ☐ Home ☐ Work ☐ Cell	Ok to leave a message? ☐ Yes ☐ No	E-mail Address
Social Security Number	Date of birth	Sex ☐ Male ☐ Female

Employer	Employer's Address
Primary Care Physician	Referring Physician
Emergency Contact, Relationship, Phone # ( )	
Primary Insurance	
Subscriber's Name	Birth date
ID Number	Group Number
Secondary Insurance	
Subscriber's Name	Birth date
ID Number	Group Number

How did you find us? (Please check all that apply)

☐Doctor ☐I was a former patient ☐Family/Friend/Co-worker recommendation ☐Love INC ☐Friend's View

☐George Fox Website ☐Internet Other_____

I verify that the above information is accurate.

PATIENT SIGNATURE (OR PARENT/GUARDIAN SIGNATURE)_____ DATE _____

I _____ (name) attest that there is no ongoing legal action surrounding my condition. This includes, but is not limited to, open litigation (lawsuit), an open motor vehicle accident case, a Workers' Compensation case, or personal damages case. I attest that no legal action is connected to the condition

I am seeking treatment for. _____ (signature) _____(date)

PHYSICAL THERAPY CLINIC: Consent for Treatment

I (please print name)_____ understand that my care as a patient at George Fox University's Graduate Department of Physical Therapy is directed by supervising licensed physical therapists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care, as well as volunteer staff physical therapists, staff psychologists and staff physicians who may be associated for the purpose of consulting.

I recognize that George Fox University's Graduate Department of Physical Therapy is a teaching institution. I agree that persons who are students may participate in my care as part of the educational programs of the institution.

☐ By checking this box, I give permission for my health data to be used **anonymously** for research purposes. ***I have fully read and understand the above agreements and authorizations.***

_____ _____
Patient Signature (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date

HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my protected health information by the George Fox University's Graduate Department of Physical Therapy (GFUDPT) for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

• GFUDPT has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

• I have the right to request restrictions to the usage and disclosure of my protected health information. • I have the right to request an alternative to the standard method of communication of my protected health information.

• I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the GFUDPT Clinic at the following address:

414 N Meridian St., V 123
Newberg, OR 97132

• I understand that while GFUDPT may honor these requests, they are not required by law to do so. • I am aware that GFUDPT reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, GFUDPT will make available a revised Notice of Privacy Practice for my review.

I acknowledge that I have been offered a copy of the GFUDPT Notice of Privacy Practices.

Signature_______________________________________ Date_______________________