Aquacare Physical Therapy
HIPAA Contact Information

Name of Patient _____ **Date of Birth:** _____ **/** _____ **/** ____
Month Day Year

An automatic appointment reminder will be automatically sent to your <u>primary</u> email address or as a text message to your cell phone.
If you do not wish to receive this reminder please indicate NO below.

How may we contact you and/or leave a message regarding APPOINTMENTS or MEDICAL INFORMATION? (Please check YES or NO)

Home Phone	**YES**		**NO**	
Cell Phone	**YES**		**NO**	
Text Message to Cell Phone *	**YES**		**NO**	
Work Phone	**YES**		**NO**	
With Another Person	**YES**		**NO**	
Mail	**YES**		**NO**	
E-Mail	**YES**		**NO**	

Standard text messaging rates will apply, and are subject to your mobile carrier rates.

E-Mail Address: _____

Preferred method of contact: (Please Circle)
Text Message E-Mail Call Cell # Call Home # Call Work #

Please list person(s) authorized to discuss medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact: _____ **Phone** #:_____

<u>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES</u>

I have been offered or have received the Notice of Privacy Practices from Aquacare Physical Therapy.

Patient Signature _____ **Date**_____