Aquacare Physical Therapy

HIPAA Contact Information

Name of Patient _____ Date of Birth: _____ / _____ / ____

Month Day Year

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

Home Phone	**YES**	**NO**
Cell Phone	**YES**	**NO**
Work Phone	**YES**	**NO**
With Another Person (Specified below)	**YES**	**NO**
E-Mail	**YES**	**NO**

E-Mail Address: _____

Preferred method of contact: (Please circle)

E-Mail Call Cell # Call Home # Call Work #

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact: _____ Phone #:_____

PLEASE PRINT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and been offered a copy of the Notice of Privacy Practices from Aquacare Physical Therapy. I am aware that a copy will be provided to me at any time by Aquacare Physical Therapy, per my request.

Patient Signature _____ Date_____