TRIANGLE THERAPEUTICS | OUTPATIENT PHYSICAL THERAPY

PATIENT INFORMATION FORM

Last Name: _____ First: _____ M.I.: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell Phone #: _____ SS#: _____

Date of Birth: _____ Sex: ❑ M ❑ F Driver's License #: _____

Email Address: _____

How did you hear about us:

❑ **Friend/Family** Name: _____ ❑ **Social Media / Internet**

❑ **Doctor** Name: _____ ❑ **Community / Events** If so, please list: _____

❑ **Yellow Pages** ❑ **Other** If other, please list: _____

Ethnicity: ❑ White ❑ Black ❑ Asian ❑ Hispanic ❑ Arabic ❑ Alaskan ❑ Am. Ind. ❑ Other: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Other Spouse's Name: _____

Emergency Contact:

Name: _____ Phone No.: _____

WORK / SCHOOL INFORMATION

STATUS:

❑ Working full-time out of home ❑ Part-time out-of home ❑ Full time from home ❑ Part-time from home

❑ Working w/ modification because of current injury ❑ Not working because of current injury ❑ Homemaker

❑ Student ❑ Retired ❑ Unemployed

Occupation (if applicable): _____

Employer's Name: _____ Phone No.: _____

Employer's Address: _____

Student ❑ Yes ❑ No If so, please list school: _____

CONSENT: I consent to the following at TTI (Triangle Therapeutics Inc.) Please Initial

_____ I voluntarily consent to outpatient physical therapy services at TTI.

_____ I am responsible for my PERSONAL ITEMS & TTI is not responsible for any items that are lost, stolen or damaged.

_____ I have received & understood the No Show & Cancellation Policy, Financial Responsibility Form and Patient Guidelines & Responsibilities.

_____ I understand my HIPAA & Privacy Rights and I can request a copy of the HIPAA Privacy Notice at any time from TTI.

_____ I grant permission to TTI to obtain information from health care providers, payor source or employer &/or school as it applies to my treatment. I also grant permission to TTI to release my medical information to healthcare providers and payor sources (insurance, third party, lawyer) for the purpose of continuing care, reimbursement or legal reasons.

_____ I grant permission for TTI to take PHOTOGRAPHS/VIDEOS of myself during my stay which may be used for advertising, marketing & promotion.

I certify that the above information are true and correct to the best of my knowledge.

Patient Signature (or Legal Guardian if Patient is a Minor): _____ Date: _____

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