Wasatch Therapy, Inc.
Patient Information Sheet

Patient Name: First	Middle	Last

Street Address	City	State	Zip

Email Address	Cell Phone	Home Phone

Sex	Date of Birth	Age	Status (child, single, married, etc.)	Drivers License or other ID#	State Issued

Employers Name	City, State	Phone #

Spouse or Parents Name	City, State	Phone #

In Case of Emergency Contact	Relationship to Patient	Phone #

Insurance

Primary Insurance	Subscriber	Relationship to Patient	Date of Birth

Secondary Insurance	Subscriber	Relationship to Patient	Date of Birth

Tertiary Insurance	Subscriber	Relationship to Patient	Date of Birth

Why did you choose Wasatch Therapy? (Select one answer only)

[ ] Doctor referred us by name [ ] Chose us from list provided by Doctor (Why?) _____
[ ] General online search (If so, why did you choose us?) _____
[ ] My insurance [ ] Walked by/in [ ] Friend or family _____
[ ] I'm a returning patient [ ] Google Reviews [ ] Social Media (Facebook, Instagram, Twitter)
[ ] Other (please describe) _____

Cancellation Policy

Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforseen circumstances, we do require 24 hours' notice of cancellations. There is a $25 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally. After missing 3 appointments without notice you may be placed on a same day scheduling policy.

Consent for Release of Information

I authorize release of any medical information concerning my treatment to my insurance company, family physician, referring physician, primary care physician, any physician in the course of care, any treating facility, my employer or rehab nurse in the case of worker's compensation, or the following persons:

[[Spouse _____ [ ] Parents, if over 18 _____
[ ] Patient's Children _____ [ ] Patient's In-Laws _____
[ ] Sports Trainer/Coach _____ [ ] Other _____

Signature of Patient or Authorized Representative Date

Consent for Treatment

I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

Signature of Patient or Authorized Representative Date