Heights
PERFORMANCE. REHAB. HEALTH.

PATIENT INFORMATION

NAME _____
LAST FIRST M

GENDER _____ AGE _____ DATE OF BIRTH _____

BILLING ADDRESS _____

CITY_____ STATE _____ ZIP CODE _____

PATIENT SSN _____-_____-_____ DRIVER'S LICENSE # _____

HOME PHONE (_____)_____ CELL PHONE (_____)_____

IS IT OKAY TO LEAVE A VOICEMAIL CONCERNING PHYSICAL THERAPY OR OTHER SERVICES? ☐YES ☐NO

EMAIL (FOR US TO SEND HOME EXERCISES)_____

I understand that Heights makes every effort to keep my private health information confidential but there are security risks associated with email that are beyond Height's control ☐OK

PREFERRED METHOD OF APPOINTMENT REMINDERS: ☐ VOICEMAIL ☐ TEXT ☐ EMAIL

EMPLOYER_____ STUDENT _____

OCCUPATION_____ WORK PHONE (____)_____

EMERGENCY CONTACT NAME_____

EMERGENCY CONTACT # (_____)_____ RELATIONSHIP_____

****IF PATIENT IS NOT RESPONSIBLE FOR PAYMENT, PLEASE PROVIDE RESPONSIBLE PARTY INFO:**

RESPONSIBLE PARTY- NAME_____

BILLING ADDRESS _____

CITY_____ STATE _____ ZIP CODE _____

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH_____

EMPLOYER_____ PHONE (____)_____

SIGNATURE REQUIRED TO SHARE INFORMATION WITH RESPONSIBLE PARTY

SIGNATURE OF CLIENT _____

INJURY INFORMATION

☐NOT APPLICABLE

☐DIRECT ACCESS or REFERRING PHYSICIAN _____

PRIMARY PHYSICIAN_____ TYPE OF INJURY _____

DATE OF INJURY _____ DATE OF SURGERY _____

REASON FOR REFERRAL: _____

INSURANCE INFORMATION

***please present card at time of service

COMPANY NAME _____

INSURANCE ADDRESS _____

CITY_____ STATE _____ ZIP CODE _____

SUBSCRIBER NAME _____ SUBSCRIBER'S BIRTHDAY _____

RELATIONSHIP TO PATIENT _____ PHONE (____)_____

EMPLOYER _____ _____ SSN _____-_____-_____

ID# _____ GROUP# _____

WAS THIS INJURY THE RESULT OF A MOTOR VEHICLE ACCIDENT?

NAME OF PERSON INSURED_____ PHONE (____)_____

NAME OF VEHICLE INSURANCE_____

INSURANCE ADDRESS _____

CITY_____ STATE _____ ZIP CODE _____

INSURANCE COMPANY FAX #_____

ADJUSTER NAME_____ ACCIDENT CLAIM #_____

WAS THIS INJURY THE RESULT OF AN INJURY AT WORK?

CLAIM # _____ NURSE/CASE MANAGER NAME_____

NURSE/CASE MANAGER PHONE (____)_____ NURSE/CASE MANAGER FAX (____)_____

DATE OF INJURY _____ LAST DATE OF WORK _____

EXPECTED RETURN TO WORK DATE _____

EMPLOYER _____ EMPLOYER PHONE (____)_____

EMPLOYER ADDRESS _____

CITY_____ STATE _____ ZIP CODE _____

INSURANCE ADDRESS _____

CITY_____ STATE _____ ZIP CODE _____

PLEASE INITIAL THE FOLLOWING

_____ I HEREBY AUTHORIZE HEIGHTS PHYSICAL THERAPY TO PROVIDE TREATMENT

_____ I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO BE PAID DIRECTLY TO HEIGHTS PHYSICAL THERAPY.

_____ I UNDERSTAND THAT IF MY INSURANCE/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT I AM RESPONSIBLE FOR THE BALANCE DUE.

_____ I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO HEIGHTS PHYSICAL THERAPY AND PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.

_____ I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY HEIGHTS PHYSICAL THERAPY. INSURANCE IS BEING BILLED AS A COURTESY. I AM RESPONSIBLE FOR PAYING ANY DEDUCTIBLE, CO-PAYS, OR SELF PAY AMOUNTS AT TIME OF SERVICE.

_____I UNDERSTAND THAT IF I NEED PAYMENT ASSISTANCE, I WILL SET UP A MONTHLY PAYMENT PLAN WITH HEIGHTS' MANAGEMENT AND THAT MY TOTAL BALANCE WILL BE PAID WITHIN 90 DAYS OF LAST DATE OF SERVICE, OR I WILL BE TURNED OVER TO COLLECTIONS.

_____I ALLOW THE RELEASE OF MY MEDICAL INFORMATION TO THE PREVIOUSLY STATED RESPONSIBLE PARTY (IF APPLICABLE)

SIGNATURE OF CLIENT/PARENT/GUARDIAN _____ DATE _____

Medical History Intake Form

Name: **Date of Birth:** **Today's Date:**

Please check ☑ any of the following conditions that you have **CURRENTLY** been diagnosed by your physician as having:

- ☐ Diabetes Mellitus
- ☐ Encephalitis (Current diagnosis)
- ☐ Hypertensive Heart Disease
- ☐ Acute Pulmonary Heart Disease
- ☐ Cardiac Dysrhythmias
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Chronic Ulcer of Skin
- ☐ Difficulty Walking
- ☐ Abnormal Posture
- ☐ Anorexia/ Bulimia
- ☐ Obesity
- ☐ Vertiginous/ Vestibular Syndromes
- ☐ Chronic Ischemic Heart Disease
- ☐ Chronic Pulmonary Heart Disease
- ☐ Congestive Heart Failure
- ☐ Venous Embolism/Thrombosis
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Sciatica (Current diagnosis)
- ☐ LumboSacral, Neuritis or Radiculitis
- ☐ Digestive Problems

Comments:

Please check ☑ any of the following conditions that you have **EVER** been diagnosed as having:

- ☐ Heart Problems
- ☐ Chest pain, Angina, Heart Attack
- ☐ Circulation Problems
- ☐ Blood Disorders
- ☐ Osteoporosis/Osteopenia
- ☐ Anxiety/ Panic Attacks
- ☐ Asthma
- ☐ Tuberculosis
- ☐ HIV/ AIDS
- ☐ Hepatitis
- ☐ Stroke
- ☐ Spinal Cord Injury
- ☐ Anorexia/Bulimia
- ☐ Gall Bladder issues
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Bleeding/ Bruising
- ☐ Other Arthritic Conditions
- ☐ Chemical Dependency/Alcoholism
- ☐ Shortness of Breath
- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Multiple Sclerosis/Parkinson's
- ☐ Traumatic Brain Injury
- ☐ Swelling of Extremities
- ☐ Menstrual Irregularities
- ☐ Concussion: when? _____ how many?____
- ☐ Pacemaker
- ☐ Anemia
- ☐ Depression
- ☐ Emphysema/Bronchitis
- ☐ Seizures
- ☐ Fainting Disorders
- ☐ Mononucleosis
- ☐ Light-Headedness
- ☐ Cancer, if so what kind/type

Comments:

Please check ☑ any of the following conditions that an immediate family member (parent, brother, sister) has ever been treated for:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Anemia
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Headaches
- ☐ Mental Illness

Comments:

Please check ☑ any of the following symptoms you have recently experienced:

- ☐ Unexplained Weight Loss
- ☐ Fever/Chills/ Night Sweats
- ☐ Numbness/Tingling
- ☐ Nausea/Vomiting
- ☐ Night Pain
- ☐ Dizziness
- ☐ Fatigue
- ☐ Accidents
- ☐ Burning
- ☐ Weakness
- ☐ Do you cough or choke when you eat or drink?

Comments:

Please list any surgeries or other conditions for which you have been hospitalized, including, the approximate date and reason for the surgery or hospitalization.

Date	Reason for surgery/hospitalization

Please list **ALL** Medications you are currently taking (including pills, injections, over-the-counter, vitamins, supplements etc.)

MEDICATION	DOSAGE	FREQUENCY	ADMINISTERED ROUTE

Comments:

Do you have allergies to Medications?

Do you have allergies to Other substances? (including but not limited to supplements, food, stings, insect bites, etc)

How many ounces of caffeinated beverages do you drink per day?

Do you use tobacco products? Yes ☐ No ☐

If so, what kind and how much per day?	☐ Cigarettes, /day,	☐ Cigars, /day	☐ Smokeless, /day

How many days per week do you drink alcohol?

If one beer or glass of wine equals one drink, how much do you drink at an average sitting?

WOMEN: Are you pregnant or think you might be pregnant? Yes ☐ No ☐ Due?

Fall Risk Assessment:

Have you fallen more than 2 times in the past 12 months?	Yes ☐	No ☐
Have you sustained an injury from a fall in the past 12 months?	Yes ☐	No ☐
Do you experience dizziness or Vertigo?	Yes ☐	No ☐
Are you afraid of falling?	Yes ☐	No ☐
Do you have memory / cognitive difficulties?	Yes ☐	No ☐
Do you use sedatives that affect your arousal during the day?	Yes ☐	No ☐
Do you have a lower extremity disability that affects walking?	Yes ☐	No ☐
Do you have vision problems that are not corrected by glasses?	Yes ☐	No ☐
Have recently felt unsteady on your feet, or in your wheelchair?	Yes ☐	No ☐

NOTES:

Patient signature: **Date:**

Relationship if other than patient / parent / guardian if minor:

OFFICE USE ONLY:

Patient has been identified as a fall risk: Yes ☐ No ☐

(Yes if patient answered yes to 3 or more fall risks questions above)

If yes, fall prevention program has been implemented: Yes ☐ No ☐

Notice of Protected Health Information Practices (Privacy Policy)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Heights Physical Therapy LLC and Heights Performance LLC ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies ad procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

   a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

   b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

   c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

   a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

   b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

   c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

   d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

   e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

   f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

   g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

   h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

   i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

   j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.

2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. **When Authorizations are Required**. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.

8. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

9. **Right to Opt-Out of Fundraising Communications**. We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by calling the Compliance Officer at (970)-641-7369 or sending an email to kaylynne@heightsperformance.com with your instructions to opt out of fundraising communications.

10. **Right to be Notified Following a Breach of Your Information.** If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.

11. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at (970-641-7389. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at kaylynne@heightsperformance.com. All complaints must be submitted to the Practice in writing at 718 N. Main St. Unit #18 Gunnison, CO 81230. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is 9-1-2013.

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR 164.520©(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and /or disclosure of personally identifiable health information about me by Heights Physical Therapy LLC and Heights Performance LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 718 N Main St. Unit #18 Gunnison, CO 81230, Attention: Compliance Officer.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in a very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):_____

I allow the following persons permission to access and speak with Heights regarding appointments, treatment and financial responsibilities:

Name _____Relationship_____
Name _____Relationship_____
Name _____Relationship_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____Accepted _____Denied
_____Not applicable
_____Other (explain)_____

_____ _____
Signature of Authorized Practice Representative Date

Performance/Physical Therapy
Attendance and 24-Hour Cancellation Policy

It is very important to your performance training/rehabilitation that you keep all of your appointments. We want to help you reach your full potential as quickly as possible. We understand that occasionally emergencies and unexpected situations arise and you may not be able to keep an appointment. Because of our busy schedule, we ask that you call **24-hours** in advance if you are unable to come. We will try to reschedule that appointment within the same week.

If you miss your appointment, cancel or change your appointment with less than 24-hours notice, you will be charged **$25**. This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24-hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

We do our best to get your treatment started on time, so please try to arrive on time. If you are more than 10 to 15 minutes late, you may have to reschedule your appointment. If you have any concerns or questions, please feel free to discuss them with me.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Heights Performance/Physical Therapy as described above. You will be billed if an appointment is missed without adherence to the cancellation policy. Thank you for your understanding and cooperation. We look forward to working with you for the best training/recovery possible.

Trent Ezzell, PT, MPT

☐ I have read and understand the above policy

Patient name (Signature)_____

Patient Name (Please print)_____ Date_____