By signing, you consent to therapy services provided by Whitefish Therapy & Sport Center.

This may include physical therapy, training services, occupational therapy, and/or speech therapy.

Services may entail the use of modalities such as therapeutic Ultrasound, E-stim, TENS, & Dry Needling. Your therapist(s) will discuss the rationale for use and will obtain verbal consent prior to treatment.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

Do you have any implants? YES or NO

If YES, what type? Medical Cosmetic

Do you have any blood borne pathogens? (HIV, Hepatitis, etc.) **YES** or **NO**

If YES, please list.

Would you like to receive appointment reminders the day before your appt? **YES** or **NO**

If YES, choose one: **TEXT** **EMAIL**

If TEXT requested, who is your cell service provider? (i.e. Verizon, AT&T, Cricket, etc)

_____

If EMAIL requested, please provide email address here:

_____

IF PATIENT IS A MINOR

Guardian's Name: _____

Mailing Address: _____

City _____ State _____ ZIP _____

Phone: _____

IF INSURANCE IS IN GUARDIAN'S NAME, PLEASE PROVIDE THE FOLLOWING:

DOB: _____

Social Security Number: _____

Additional Guardian's Name: _____

Mailing Address: _____

City _____ State _____ ZIP _____

Phone: _____

GUARANTOR Name - If different from above

_____

DOB: _____

Social Security Number: _____

Guardian's Printed Name: _____

Guardian's Signature: _____

DATE signed: _____