

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 or 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: _____