Artemis Physical Therapy Patient Information

1 *Client Information*

Last Name	First Name	MI
Address	City	Zip
Date of Birth	☐ Female ☐ Male	Employer (optional)

2 *Contact Information*

Home Phone	Cell Phone	Work Phone (optional)
Email		
Emergency Contact Name	Emergency Contact Phone Number	Relationship to Patient

3 *Health Care Team Information (Optional)*

Provider's Name	Clinic Name/Contact Information
Provider's Name	Clinic Name/Contact Information
Provider's Name	Clinic Name/Contact Information

4 *How did you hear about Artemis Physical Therapy?*

☐ *I understand that Artemis Physical Therapy, PLLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.*

☐ *E-MAIL, VOICEMAIL and TEXT COMMUNICATION OPTION: I hereby give my consent for the use of email, voice and/or text messaging to communicate about my care at Artemis Physical Therapy, PLLC including pending appointments. I understand that such communications may include personal healthcare information and that such transmissions are not encrypted. Such communications are limited to me and parties with whom I give written permission to communicate. At no time will such contact information be shared or publicized. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.*

X _____ **X** _____

I VERIFY THAT THE ABOVE INFORMATION IS ACCURATE Date