



New Client Registration

Today's Date: _____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Marital Status: _____ Gender (Circle): Male / Female

Home Phone #: _____ Cell Phone #: _____

Fax #: _____ Email: _____

Employer: _____ Occupation: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Email: _____

Referral Information:

Doctor Google Advertisement Facebook Friend Family

Other: _____

Communication consent

New regulations require that anyone using email and text messaging to communicate with healthcare providers understand and agree to certain conditions and limitations.

1. The transmission of client information via email has a number of risks, including but not limited to: email is not secure; email can be intercepted, misaddressed, altered, forwarded, or used without authorization or detection; email may be circulated, forwarded and stored in paper and electronic files even after the sender or recipient has deleted his or her copy.
2. The practice will use all reasonable means to protect the security of the email and text message, however we cannot guarantee email and text messaging confidentiality. The practice is not liable for improper disclosures unless they are caused by the Practice's intentional misconduct.

In regards to communication with my therapist, I am aware that email and text messaging is not a secure method of communicating. By initiating or responding to an email or text message, I am giving my consent to communicate in this manner and understand that there are risk to my protected health information. I have read and understand the email disclaimer and give consent to Restore and Revitalize Physical Therapy, LLC to correspond with me via email, if necessary.

Client's Initials _____

Client Signature: _____ Date: _____