



LAST NAME		FIRST NAME	MI	DOB	SOCIAL SECURITY #	SEX
HOME ADDRESS		CITY, STATE	ZIP CODE	HOME # ()	CELL # ()	
MARITAL STATUS	HAVE YOU EVER BEEN TREATED AT THIS CLINIC BEFORE?					IF YES, WHEN?
EMPLOYMENT STATUS EMPLOYED () STUDENT () N/A ()		EMPLOYER NAME / SCHOOL NAME		TITLE / POSITION		
WORK ADDRESS		CITY	ZIP	WORK # ()		
E-MAIL ADDRESS (OPTIONAL)						
GUARANTOR: If this patient is a minor , please state the name, phone number and address of the person(s) financially responsible for all balances relating to this treatment.						
LAST NAME		FIRST NAME			RELATIONSHIP	
ADDRESS		CITY, STATE			ZIP	
HOME # ()			WORK # ()			
IN CASE OF EMERGENCY CALL						
LAST NAME		FIRST NAME			RELATIONSHIP	
ADDRESS		CITY, STATE			ZIP	
HOME # ()			WORK # ()			
ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREAT						
I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO PROBILITY PHYSICAL THERAPY IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.						
A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONEL OF PROBILITY PHYSICAL THERAPY AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE. I CONSENT TO BEING KNOWINGLY PHOTOGRAPHED OR VIDEOTAPED BY AUTHORIZED PERSONEL OF PROBILITY PHYSICAL THERAPY FOR MEDICAL REASONS SUCH AS POSTURAL CORRECTION, GAIT/MOVEMENT ANALYSIS OR EDUCATIONAL PURPOSES.						
AUTHORIZED SIGNATURE				TODAY'S DATE		