ORTHOPEDIC EDGE physical therapy

Do we have your permission to leave a message on your answering machine/voicemail with a family member or a legal representative regarding appointments, billing, or other matters regarding your treatment?

Yes_____ No_____ Other _____ (Please specify)

May we call you at work?

Yes_____ No_____

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices.

_____

Print Patient's Name

_____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____