PATIENT INFORMATION FORM

First Name: _____ Last Name: _____

DOB: _____ Sex: ☐ M ☐ F Drivers Lic #: _____ SS #: _____-_____-_____

Street Address: _____ City _____ State ____ Zip _____

Home # (_____) _____ Cell # (_____) _____

Email: _____

EMERGENCY CONTACT: NOT LIVING WITH YOU

Name: _____ Phone (_____) _____

Address: _____

Relationship: _____

PATIENT AUTHORIZATION

CONSENT

I authorize Brighton Therapy to provide my treatment as prescribed by my physician.

Signature: _____ Date: _____

A photocopy of this authorization will be considered as valid as the original.

CANCELLATION POLICY

I understand I will be charged 1 session for a no-show or cancellation of less than 24 hours notice.

Initial Here: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Brighton Therapy's Notice of Information Practices. I understand that Brighton Therapy 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. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Brighton Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Brighton Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature: _____ Date: _____