COASTAL THERAPY, INC.

Please complete all questions

Today's Date: ______________________

Last Name: ____________________ First Name: ____________________ MI: ______

Home Address (No PO Boxes) ____________________ Email ____________________

City ____________________ State ____________________ Zip Code ____________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Date of Birth ______________ AGE: __________ Social Security No.: ______________

Marital Status: □Single □Widow □Married □Divorced Sex: (circle one) Male / Female

Date of Injury: ____________________ Type of Injury: ____________________

What Physician referred you for therapy? ______________________________

When is your next appointment with the referring Physician? ______________________________

Employer: ____________________ Occupation ____________________

Employer's Address ____________________ Main Office # ____________________

Spouse or Guardian Information

Name: ____________________ Relationship: ____________________

Date of Birth ____________________ Social Security No. ____________________

Phone No.: ____________________ Employer ____________________

Emergency Contact Information

Nearest relative not living with you ____________________ Phone No. ______________

Nearest friend not living with you ____________________ Phone No. ______________

CONSENT FOR MEDICAL TREATMENT

I, ______________________________ (Patient's Name) suffer from a condition requiring diagnostic procedures and medical treatment. I voluntarily consent to such care at Coastal Therapy, Inc. (hereafter Coastal Therapy) as may be necessary or beneficial in the professional judgment of my physician and therapist. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the effect of such diagnostic procedures and medical treatment of my condition. I have read the foregoing consent, and I am aware of its contents and fully understand same. I hereby affirm that I am signing this consent in the following capacity as set forth in O.C.G.A. Section 31-9-2.

( ) 1. Any adult for himself/herself;
( ) 2. An agent designed by a Durable Power of Attorney for Health Care; *
( ) 3. Any married person, whether an adult or a minor, for himself/herself or for his/her spouse; *
( ) 4. Any parent, whether an adult or minor, for his/her minor child; *
( ) 5. Any person temporarily standing in loco parentis, for the minor under his/her care; *
( ) 6. Any guardian for his/her ward. *

***In the absence of any of the individuals listed above*;**

( ) 7. Any adult for his/her brother or sister; *
( ) 8. Any grandparent for his/her grandchild; *
( ) 9. Any adult child for his/her parent; or *
( ) 10.Any parent for his/her adult child. *

- **In accordance with HIPAA Regulations and Guidelines.**

Signed ______________________________
Patient or person responsible - Relationship

Date __________ Witness ______________________________