NOTIFICATION POLICY

Name:____

It is our policy not to release confidential and or unauthorized information by home telephone, answering machine, work telephone, voice mail, and cell phone. When returning calls and answering machine picks up, we do not leave a message unless it is an appointment reminder. Information will not be left with unauthorized person who may answer the phone . If you would like to have information released to someone other than yourself please complete the following.

I authorize the staff of All Star Physical Therapy to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

____Yes ____No Home Telephone___________________________________

____Yes ____No Home Answering Machine___________________________

____Yes ____No Fax-Home____

____Yes ____No Work Telephone____________________________________

____Yes ____No Work Voice Mail____________________________________

____Yes ____No Fax Work ____

____Yes ____Cell phone and voice mail______________________________

Email Address: ____

Please list names of authorized people we may leave messages with: (i.e. spouse, boyfriend, girlfriend, parent grandparent etc.)

Name: ___________________________________ Relation: _______________________ Phone #:_________________

Name: ___________________________________ Relation: _______________________ Phone #:_________________

Name: ___________________________________ Relation: _______________________ Phone #:_________________

Who may we discuss you financial situation with?

Name: ___________________________________ Relation: _______________________ Phone #:_________________

Name: ___________________________________ Relation: _______________________ Phone #:_________________

Patient signature: ____ Date:___________________________