

## Registration for Non-PT Services

**For the client (i.e. the person receiving the service):**

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone:	Date of Birth:	E-mail Address:	
Work Phone:	Employer:	Occupation:	
Emergency Contact Phone:	Emergency Contact Name:	Emergency Contact Relationship to Client:	

**For the guardian (if applicable):**

Last Name:	First Name:	Middle Initial:	Relationship to Client:
Address:	City:	State:	Zip Code:
Home Phone:	Date of Birth:	E-mail Address:	

**Please read the following carefully!**

- I verify that the above information is correct. I authorize Zombro Physical Therapy (ZPT) to share my information, and any information regarding my condition, with my physician(s) and any other members of my healthcare team. This signed statement will be placed in my file to indicate my authorization for information sharing.
- I understand that I am ultimately responsible for the payment of all charges. I accept responsibility for any and all charges incurred. Furthermore, I agree to pay 100% of my charges at the time of service.
- I read and understood the ZPT Privacy Policy.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness Initials: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness Initials: \_\_\_\_\_