Personal Health and Billing Information

I hereby give permission to Hilton Head Physical Therapy and any agents affiliated with them to discuss my healthcare and billing information with the following individuals:

NAME	DOB	RELATIONSHIP	PHONE#

NAME	DOB	RELATIONSHIP	PHONE#

Emergency Contact

NAME _____ Phone# _____

ADDRESS _____

CITY, STATE, ZIP _____

Medical Contact Information

Primary Care Doctor _____ Phone _____

Signature _____ Date _____