

**Mark Farris Pirtle, DPT, CSCS, COMT**

2506 E. Drachman Street

Tucson AZ 85716

Phone (520) 250-9027 Fax (520) 795-3622

**PATIENT DEMOGRAPHIC INFORMATION**

**DATE:** \_\_\_\_\_

**PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ MESSAGE/CELL PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

SEX: F \_\_\_ or M \_\_\_ AGE: \_\_\_\_\_

TYPE OF SURGERY (If applicable): \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ CELL/WORK NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**REFERRAL SOURCE INFORMATION**

NAME OF THE PERSON WHO REFERRED YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ **DIAGNOSIS:** \_\_\_\_\_ (If known)

**DATE OF REFERRAL:** \_\_\_\_\_ **SURGERY DATE: (IF APPLICABLE)** \_\_\_\_\_

**Consent to Treat, Information Release, Payments, Refunds, and Cancellation/No-Show Policy**

1. I am seeking a physical therapy and/or stress-illness consultation and therefore do consent to the evaluation and treatment services jointly deemed appropriate by me and Dr. Pirtle.
2. I understand that without my specific authorization, no information will be released by Dr. Pirtle to any third party, including my physician(s), therapists, insurance carrier(s), attorney(s), family, coach(es), etc.
3. I understand that I am responsible for all services consented to by me and provided by Dr. Pirtle.
4. If I am in any way dissatisfied with the services provided by Dr. Pirtle I may ask for a refund. It is my responsibility however to inform Dr. Pirtle of such dissatisfaction immediately. I will not wait until the end of a session to do so. This policy is in place to ensure I receive the value to which I'm entitled, while at the same time respecting Dr. Pirtle's time.
5. **I understand that cancellations without 24-hour notice or "no-shows" may be subject to the full appointment fee.**

**THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND I HAVE READ AND UNDERSTAND THE POLICIES STATED ABOVE.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian, if minor)