www.SterlingOSPT.com
2525 Washington St.
Pella, Iowa 50219
641.621.1401

Patient Information

Patient □ Policyholder

First _____ Last _____

Birth Date _____ SSN _____

Home _____ Cell _____ Work _____

Address _____
City State Zip

Email: _____ Employer _____

Family Physician _____ Referring Physician _____

Policy Holder (If different than patient)

First _____ Last _____

Birth Date _____ SSN _____

Home _____ Cell _____ Work _____

Address _____
City State Zip

Email: _____ Employer _____

Emergency Contact

Name _____ Phone Number _____

- I agree to give 24 hours notice when changing my appointment except for illness or unforeseen circumstance. Failure to do so will result in a $15 charge.
- You may leave a message on my answering machine regarding my physical therapy care.
- As this minor's parent/guardian, I authorize Sterling OSPT to provide treatment.
- HIPAA Privacy Information is available to me upon request.

_____ _____
Signature of Patient or Legal Guardian Date