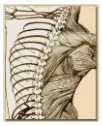

MANUAL THERAPY ASSOCIATES INC.

Patient demographics Today's date: _____

Name: _____ Date of birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ home: _____ Email: _____

Name of insurance: _____ (for information only) MTA will not bill insurance.

Chief complaint: _____

Who can we thank for referring you? Friend Family Other? _____

Emergency contact: _____ phone: _____

Is your injury related to a motor vehicle accident? Yes /No

If you answered yes, please complete questions 1-5, otherwise skip to signature line.

1. Date of injury: _____
2. do you have an attorney? Name/phone number: _____
   _____
3. Auto insurance company: _____
4. Adjustor name: _____ phone number: _____
5. Claim number: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorized Manual Therapy Associates, INC to release any information acquired in the course of my treatment necessary to process insurance claims. I hereby consent to treatment as deemed necessary by the treating physical therapist(s) and referring physicians(s).

CANCEL / NO-SHOW: Please note that you will incur a $**60.00** fee for a no-show/cancellation fee if you do not call at least 24 hours prior to the scheduled appointment.

I certify that I have read and understand the above hold harmless clause and release of information clause. The information I have provided on this form is true and correct to the best of my knowledge. A copy of this form is valid as the original.

X_____ date: _____

Patient/legal guardian signature

12001 W. 63rd place, Suite 5, Arvada CO 80004 Ph: 303-456-2671 /Fax: 303-456-0220