ADVANCED ORTHOPAEDIC
Physical Therapy PSC

Confidential Communication Authorization

Please specify who we may contact regarding your physical therapy matters or billing issues.

Home Phone

Give information to spouse	YES	NO	N/A
Give information to a parent/guardian	YES	NO	N/A
Give information to a child	YES	NO	N/A
Leave information on voice mail	YES	NO	N/A

Work Phone

Leave information on voice mail	YES	NO	N/A

Cell Phone

Leave information on voice mail	YES	NO	N/A

E-Mail

Email information to personal email	YES	NO	N/A

Mail

Send information addressed to you (may include postcards)	YES	NO	N/A

Patient Signature_____ Date_____