Governors Square
Grand Cayman, Cayman Islands
(345) 745-2727
info@astepaheadphysio.com

Patient Information/Authorization to Treat

Patient Name, Last: ________________________________ First: _________________________________

Date of Birth: Day_______ Month _______Year ________ Gender: Male / Female

Phone: (H)________________________ (W) _______________________ (C)________________________

PO Box: _________________________________ Post Code: __________________________________

Street Address: __________________________________ District: ________________________________

Email Address: ____

Employer: __________________________________Occupation:__________________________________

Referring Doctor:____

Insurance Company: ____

Emergency Contact:

Name:____ Phone Number: ____________________

Authorization to Treatment

I understand that I have been referred for rehabilitative treatment and care to A Step Ahead Physiotherapy, Ltd. I understand that I have the right to ask and have any questions answered prior to receiving any treatment. I understand that I have the right to stop treatment at any time and that I will inform the therapist of any discomfort I may experience whilst receiving treatment. By signing this agreement, I consent to have this facility provide treatment and care as prescribed by my physician and/or recommended by my therapist.

____ Date _______________________
Signature of Patient/Guardian

All co-payments are due at the time of service. Thank you.