Prefix	First	Middle	Last	Suffix
	Aleah		TEST	

Date of Birth

12/15/2020

Initial

An

Initial

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Initial

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Initial

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Initial

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Please indicate below how I may share protected health information with you.

- [ ] Home voice mail/machine
- [x] Via texts to my cell phone

- [ ] My cell phone voice mail
- [ ] My work voice mail
- [ ] Via my email address

Initial

AN

Initial

AN

Consent

- [x] I have read and agree to abide by the above policies.

Prefix	First	Middle	Last	Suffix
	Aleah		TEST	

Date

12/16/2020

Initial

AN

Consent

- [x] By signing, I agree to have Medisource Healthcare Solutions bill my insurance and/or process my credit card after each visit on behalf of Valerie C. Wondra, PT and Move2Play Pediatric Physical Therapy (when applicable for non-Medicaid clients).

Prefix	First	Middle	Last	Suffix
	Aleah		Niemczyk	

Date

12/16/2020