

Nevada Physical Therapy

PATIENT INFORMATION

LEGAL NAME OF PATIENT				SOCIAL SECURITY NUMBER			
BILLING ADDRESS/P.O.BOX			APT#	CITY		STATE	ZIP
HOME PHONE	CELL PHONE	BIRTH DATE	AGE	SEX	MARITAL STATUS		
EMPLOYER/STUDENT		OCCUPATION			HOW LONG?		
WORK PHONE	NAME OF REFERRING PHYSICIAN			E MAIL ADDRESS			
AREA OF BODY TO BE TREATED	DATE OF INJURY/ACCIDENT OR ONSET OF CONDITION			DATE OF SURGERY, IF APPLICABLE			
WHO MAY WE CONTACT IN CASE OF EMERGENCY (NAME, RELATIONSHIP, PHONE)				LOCAL ALTERNATE CONTACT PHONE NUMBER			
HAVE YOU RECEIVED ANY PHYSICAL THERAPY TREATMENTS THIS CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, WHERE AND HOW MANY VISITS?				
HAVE YOU HAD AN MRI OR SPECIAL DIAGNOSTIC STUDIES RELATED TO YOUR CURRENT CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, WHERE AND WHEN?				
WAS THIS DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOW WERE YOU INJURED?					
WAS THIS A WORK RELATED INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER AT TIME OF INJURY		CASE MANAGER OR ADJUSTER NAME		CLAIM OPEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
WAS THIS DUE TO AN AUTOMOBILE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			IN WHAT STATE DID AUTOMOBILE ACCIDENT OCCUR?				

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME OR COMP CARRIER NAME				INSURANCE COMPANY PHONE			
MAILING ADDRESS/P.O.BOX			CITY	STATE	ZIP		
POLICY HOLDER (as it appears on insurance card)		RELATION TO PATIENT		POLICY HOLDER'S DATE OF BIRTH			
MEMBER NUMBER OR SUBSCRIBER ID NUMBER			POLICY/GROUP OR CLAIM NUMBER				
POLICY HOLDER'S EMPLOYER				WORK PHONE NUMBER			

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME		INSURANCE COMPANY PHONE	
POLICY HOLDER'S NAME	DATE OF BIRTH	MEMBER NUMBER OR SUBSCRIBER ID NUMBER	

HIPAA COMPLIANCE

I hereby acknowledge that I have been offered a copy of NPT's Notice of Privacy Practices.

SIGNATURE	DATE
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The undersigned hereby consents to and authorizes the following:

- 1) Payment to Nevada Physical Therapy Inc. (NPT) and all providers of services related to this treatment of any insurance benefits or from any other entity to the undersigned;
- 2) Federal Truth in Lending Statement - Whether the undersigned signs as agent or as patient that in consideration of services to be rendered to the patient, he or she hereby individually obligates himself/herself to pay the account of (NPT) in accordance with the regular rate and terms of (NPT). Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.
- 3) Release of patient's medical records and information to any person or entity responsible for payment to (NPT), the medical provider or the patient for services rendered; and
- 4) Treatment by (NPT) and its employees

THE UNDERSIGNED ACKNOWLEDGES AND AGREES THAT HE/SHE HAS READ THE ABOVE AND IS ULTIMATELY LIABLE FOR ANY UNPAID BILLS RENDERED.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN	DATE	SIGNATURE OF INSURED IF OTHER THAN PATIENT	DATE
SIGNATURE OF WITNESS		DATE	