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? □ YES □ NO	**IF YES, WHERE AND HOW MANY VISITS?**
HAVE YOU HAD AN MRI OR SPECIAL DIAGNOSTIC STUDIES RELATED TO YOUR CURRENT CONDITION? □ YES □ NO	**IF YES, WHERE AND WHEN?**
WAS THIS DUE TO AN ACCIDENT? ☐ YES ☐ NO	**HOW WERE YOU INJURED?**

WAS THIS A WORK RELATED INJURY? ☐ YES ☐ NO	**EMPLOYER AT TIME OF INJURY**	**CASE MANAGER OR ADJUSTER NAME**	**CLAIM OPEN? □YES □NO**

WAS THIS DUE TO AN AUTOMOBILE ACCIDENT? □ YES ☐ 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

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