PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

SSN: _____ DOB: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Ok to call? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Work Phone: _____ Ok to call? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Cell Phone: _____ Ok to call? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Patient Employer: _____ Occupation: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Active Military ☐ Retired ☐ Disabled ☐ Out on Leave

Student Status: ☐ ull-Time ☐ art-Time School: _____

Email Address: _____ Referring Physician: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

Are you currently receiving Home Health for any reason? ☐ YES ☐ NO

Primary Insurance

Insurance Carrier: _____ Subscriber: _____

Patient's Relationship to Subscriber: ☐ SELF ☐ Spouse ☐ Child ☐ Other Policy ID #: _____

Subscriber's DOB (if other than SELF): _____ Subscriber's SSN (if other than SELF): _____

Subscriber's Employer (if other than SELF): _____ Subscriber's Address: _____

Secondary Insurance

Insurance Carrier: _____ Subscriber: _____

Patient's Relationship to Subscriber: ☐ SELF ☐ Spouse ☐ Child ☐ Other Policy ID #: _____

Subscriber's DOB (if other than SELF): _____ Subscriber's SSN (if other than SELF): _____

Subscriber's Employer (if other than SELF): _____ Subscriber's Address: _____

HIPAA: By signing this form I acknowledge that I have been informed of the HIPAA "Notice of Information Practices" posted in the waiting room at *North Bay Therapy* and understand it completely. I can request a copy of this form.

CONSENT: By signing this form, I agree and give my consent for *North Bay Therapy and R. Keith Ganey, DPT, SCS, LATC to* furnish physical therapy treatment considered necessary and proper in treating my physical condition. I acknowledge that the above-named therapist and his assistants have given no guarantee or assurance as to the results that may be obtained from the procedures performed at *North Bay Therapy*. I also give my consent for *North Bay Therapy* to call the listed phone numbers above regarding appointments, insurance billing, and all other matters regarding my therapy. This may also include the billing dept. and off-site collection agency shall my account become delinquent.

ATTESTATION: I attest that the information provided in this document is true and accurate to the best of my knowledge and ability. I will notify *North Bay Therapy* of any changes in my status or the above information.

_____ _____ _____

Patient Signature | Parent/Guardian Signature if Patient is a Minor | Date