NORTH SALINAS PHYSICAL THERAPY

* PATIENT INFORMATION FORM *

NAME: _____ Birthdate: ____/_____/_____
First Middle Last

Age: _____ ☐ Male ☐ Female Social Security #: _____

Work Injury: ☐ Yes ☐No Date of Injury: ____/_____/_____ Auto Accident: ☐ Yes ☐ No

Referring Physician: _____

PATIENT INFORMATION	EMPLOYER INFORMATION
Address: _____ City: _____ State, Zip: _____ Home Phone: _____ Cell Phone: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Name of Employer: _____ _____ Address: _____ City, State, Zip: _____ Employer's Phone: _____ Occupation: _____
PERSON TO NOTIFY IN EMERGENCY	**COMPLETE IF PATIENT IS A MINOR**
Name: _____ Best Phone Number: _____ Relationship to Patient: _____	Parent / Guardian's Name: _____ DOB: ___/___/___ Address: _____ City, State, Zip: _____ Social Security #: _____ Employer Name: _____ Address: _____ City, State, Zip: _____ Phone: _____
INSURANCE INFORMATION	**ATTORNEY INFORMATION**
Primary Carrier: _____ _____ **Insured's Name and DOB:** _____ _____ Insured's Employer: _____ **Secondary Carrier:** _____ Insured's Name and DOB: _____ _____ Insured's Employer: _____	Attorney Name: _____ Address: _____ City, State, Zip: _____ Phone: _____

Consent for Care and Treatment: I do hereby agree and give my consent for North Salinas Physical Therapy to evaluate and furnish medical care and treatment considered necessary and proper in treatment my physical condition:

Patient / Guardian Signature: _____ Date: _____

Benefit Assignment / Release of Information: I hereby assign and authorize payment directly to North Salinas Physical Therapy of any medical benefit or series of medical benefits to which I am entitled, including Medicare, private insurance, and third party payors. I authorize NSPT to release medical records and supporting documentation as compiled in the medical record for this treatment for the purposes of benefit payment, payor authorization, and to my physician.

Patient / Guardian Signature: _____ Date: _____

Financial Policy: We request payment at the time of service. We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance cards. If a co-payment / deductible is part of your plan, we request that portion of your payment at the time of service. Failure to give a ***24 hour notice for cancelled appointments will result in a $25.00 missed appointment fee that will NOT be billed to your insurance and will be reported to your employer if you are being treated under Worker's Compensation***. I understand that I am financially responsible for all charges, regardless of insurance coverage, and that I will be expected to pay if my insurance has not paid within 60 days.

Patient / Guardian Signature: _____ Date: _____