

North Bay Therapy
1990 Popps Ferry Rd.
Biloxi, MS 39532-2105
228-385-9000
NEW PATIENT INFORMATION

PATIENT INFORMATION (CONFIDENTIAL)

TODAY'S DATE: _____

Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Social Security Number: _____ Gender: M F Marital Status: Married Single Divorced Widowed
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Referring Physician: _____ Primary Care Physician: _____
Symptoms/Injury Date: _____ Accident Related: Yes No Auto Worker Comp
Emergency Contact Person: _____ Phone: _____ Relationship: _____
Have you had any Physical Therapy/Chiropractic /Home Health treatment this year? Yes No When? _____

EMPLOYMENT INFORMATION

Employer/School: _____
Employer Address: _____ Employer Phone: _____

RESPONSIBLE PARTY-(NAME SHOWING UP ON STATEMENT)

Name of Person Responsible for this Account: _____ Relationship to Patient: _____
Address: _____ Home Phone: _____
DOB: _____ Social Security #: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
DOB: _____ SS#: _____
Insurance Company: _____ Policy/ID#: _____ Group#: _____
Ins Co. Address: _____ City: _____ State: _____ Zip: _____
I will be paying today by Cash _____ Check _____ Credit Card _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____ Relationship to Patient: _____
DOB: _____ SS#: _____
Insurance Company: _____ Policy/ID#: _____ Group#: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay all costs of the collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection. I have read and understand all of the above information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I authorize the performance upon myself/dependent, procedures in the realm of Physical Therapy, for the State of Mississippi, to be performed by or under the directions of R. Keith Ganey, DPT, SCS, L/ATC. I acknowledge that the above named therapist or his assistants have given no guarantee or assurance as to the results that may be obtained from the procedures

Patient Signature

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PATIENT ASSIGNMENT OF BENEFITS

Patient Name: _____ Date: _____

Insurance Company: _____

Insurance Group: _____ Policy #: _____

Patient SS#: _____ - _____ - _____

I hereby instruct and direct, my insurance company, to pay by check made out and mailed to:

North Bay Therapy
1990 Popp's Ferry Rd
Biloxi, MS 39532

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Patient Name: _____

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For the professional or medical expense benefits allowable, and payable under my current insurance policy, as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Acknowledgement of Privacy Practice

By signing this form, I acknowledge that I have been informed of the HIPPA Notice Of Information Practice posted at the front desk and understand it completely. I may request a copy of this form.

Signature of Patient

Date

Employee Signature

Date

Patient Signature