## 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

Email Address:_____ Referring Physician: _____

Emergency Contact Name:_____ Phone:_____ Relation: _____

Patient Employer:_____ Occupation: _____

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

Student Status: ☐ Full-Time ☐ Part-Time School: _____

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