

**PATIENT INFORMATION**

<b>Patient Name</b>	Nickname	DOB	Social Security #	Home Phone
<b>Address</b>	City and Zip Code	Marital Status S M D W LEGALLY SEP	Gender M F	Cell Phone
<b>Email</b>	Referring Physician	Seeking Therapy for	Date and Type of Surgery	
<b>Occupation</b>	Patient's employer and work address			Employer's Phone
<b>Primary Care Physician</b>	Emergency Contact Name		Contact's #	Relation to Patient
<b>Is your condition the result of an accident?</b>	If so, provide how, where and in which state the injury occurred.		<b>If injury is due to auto/other accident, please ask for PI form</b>	
<b>Date of Injury, If Applicable</b>	If work-related injury, employer name at time of injury		Case Manager/Claims Adjustor name and Phone	

**INSURANCE INFORMATION**

<b>Primary Insurance Name</b>	Policy#, WC or Auto Group # Claim #	Policy Holder's DOB	Relationship to Patient
Policy Holder's Name(if other than pt)	Policy Holder's Home Address	Policy Holder's Phone	
Policy Holder's Employer, Work address and Phone (if other than patient)		Policy Holder's SSN	Copay Amount
<b>Secondary Insurance Name</b>	Policy#, WC or Auto Group # Claim #	Policy Holder's DOB	Relationship to Patient
Policy Holder's Name(if other than pt)	Policy Holder's Home Address		Policy Holder's Phone
Policy Holder's Employer, Work address and Phone (if other than patient)		Policy Holder's SSN	Copay Amount

**OTHER PATIENT INFORMATION**

Have you had any Physical Therapy or Speech Therapy This Year? Yes No If so, How many visit? PT\_\_\_\_\_ ST\_\_\_\_\_

Have you had any Occupational Therapy This Year? Yes No If so, How many visit? OT\_\_\_\_\_

Are you receiving home health services of any kind at this time? **Yes No If yes, please inform the receptionist at this time**

Have you received any type of home health services? Yes No If so, when were you discharged (your final visit)?  
 \_\_\_\_\_

Regarding Privacy: I have read a copy of NSPT's Privacy Policies (sign & date)

\_\_\_\_\_  
 NSPT/VPS Staff may leave messages with a person at home\_\_\_\_\_, and/or on my voicemail/answering machine at home\_\_\_\_\_, work\_\_\_\_\_, or cell phone\_\_\_\_\_. (Please initial all that are acceptable to you.)  
 NSPT/VPS can discuss my care or account with the following individuals:

I give my consent for treatment, authorize the release of necessary information to insurance carriers and appropriate personnel, and request that my insurance carriers pay NSPT directly. If direct payment is not permitted, I request that payment be issued jointly to NSPT and myself and mailed directly to NSPT. I will endorse checks to NSPT who may cash and apply to my account accordingly. I understand I am financially responsible for any and all charges incurred and that I will be charged a late fee in the amount of 15% per month for balances billed that remain unpaid after 90 days. In the event my account is referred to a debt collector, I understand I will be responsible for all costs incurred to collect the debt in addition to my account balance.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_