# Patient Information

**Welcome!** Thank you for selecting my practice. In order to serve you properly, I will need the following information. All information will be kept strictly confidential. (Please print clearly)

Patient Name_____
StreetAddress_____
City _____ State_____ Zip/Postal Code_____
Phone: (Home)_____ (Cell)_____
(Fax)_____
Email_____
Date of Birth_____ (M/D/YR) (Circle) Male / Female

If Child,
Parent/ Guardian's Name_____

Employer _____
Occupation_____
Referring Physician_____ Family Physician_____
Insurance Carrier(s)_____

In Case of emergency, please provide us with the name of the nearest relative not residing with you: Name_____
Phone_____
Relationship_____

I understand that payment is expected on the day of each treatment, with the exception of Worker's Compensation insurance coverage. I am responsible for all charges, regardless of insurance coverage. I understand that Rebecca Nash, DPT is not a Medicaid or Medicare Provider and therefore cannot submit payment for reimbursement. I understand that Rebecca Nash, DPT expects prompt payment of all bills for services rendered. I am responsible for prompt payment for all such bills.

Patient/ Guardian Signature_____
Date_____

**Rebecca Nash, DPT**
323.574.7000
rebeccabierlynash@gmail.com