REGISTRATION FORM

THERAPIST NAME: ____ APPT DATE: _______________

PRIMARY CARE/REFERRING PHYSICIAN: ____

PATIENT NAME: ____ **Date of Birth**: ________________

ADDRESS: ____

CITY: ____ STATE: ____________ ZIP: ________

SS#: _______________________________ EMPLOYER: ____

PHONE: _______________________________ WORK PHONE: ____________________________________

SEX: Female ____ Male _____ MARITAL STATUS: Single____ Married ____ Divorced ___

RESPONSIBLE PARTY: __________________________________ **SS#** ____________________________

ADDRESS: _____________________________ CITY/STATE: _______________________ ZIP: ________

PHONE: ______________________________ WORK PHONE: _____________________________________

INSURANCE #1: ____

POLICY #: _____________________________________ GROUP #: ______________________________

Policy Holder: ____ **SS #**: __________________________

INSURED Date of Birth: ___________________ EMPLOYER: ______________________________________

INSURANCE #2: ____

POLICY #: _____________________________________ GROUP #: ______________________________

Policy Holder: ____ **SS #**: __________________________

INSURED Date of Birth: ___________________ EMPLOYER: ______________________________________

EMERGENCY CONTACT (OTHER THAN SPOUSE)

NAME: ____ RELATIONSHIP: ______________________

HOME PHONE: ________________________________ WORK PHONE: ____________________________

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company.

I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorized therapist billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to therapist. If I have Medicare insurance, I authorize the therapist to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by the therapist by written request.

SIGNATURE ____ DATE ______________________

WITNESS ____ DATE _____________________