Registration Information
Please Print

________________ (Date)

Patient Name: Last________________ First________________ M.I.________

Address____ City_

________________ State________ Zip______-______

Home Phone (   ) ________________ Work Phone (   ) ________________

Cell Phone (   ) ________________ Other Phone (   ) ________________

Age____ Date of Birth____-____-____ Female/Male____ Social Security#____________

Marital Status________ Employer/School________________________

Referred by____

Primary Care Physician/ Address/ Phone________________________________

In Case of Emergency call: Name________________________ Phone# (   )________

Person Responsible for Payment________________________ DOB:____________

-Relationship to Patient________________________ Social Security#____________

-Employer of Person Responsible for Payment________________________________

-Address of Responsible Party Unless Same as Above________________________

-City________________ Sate____________ Zip________-________

I am responsible for full & timely payment for services I request: ________________________
Signature of Responsible Party

Complete this part only if you plan to request reimbursement from insurance. Please discuss any parts of this that need clarification with your physician/therapist.

1. Check whether your insurance coverage requires pre-certification (the phone number should be on your card.
2. Ask a secretary to make a copy of your insurance card(s).
3. Primary Insurance: ________________ Policy Holder: ________________ DOB: ________
4. Secondary Insurance: ________________ Policy Holder: ________________ DOB:________
5. I authorize my physician/therapist to release information about my condition and treatment to my medical insurance carrier for reimbursement. I am responsible for full and timely payment for services I request. It is my responsibility to contact the insurance carrier promptly when payment is delayed or miscalculated.

   Signature of Responsible Party________________________ Date____________

6. I authorize the insurance company to reimburse my physician/therapist directly.

   Signature of Responsible Party________________________ Date____________

For office use only: C____________ D____________ E____________ F____________

Patient will submit for insurance themselves________ Yes________ No. Other arrangements agreed upon:

____

Therapist Name________________