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_____