Registration Information _______________________

Please Print **(Date)**

Patient Name: Last_________________________**First**_____________________**M.I.**__________

Address____

City______________________________**State**_______________**Zip**__________-___________

Home Phone(   )_______________________**Work Phone(   )**____________________

Cell/Other Phone(   )____________________**Email Address**_____________________

Age______ **Date of Birth**_______-______-_______**Female/Male** ______**Social Security #**______________

Marital Status___________**Employer/School**___________________________________

Referred by________________________________**Email**__________________________

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______________________________**State**__________**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:**__________________**PolicyHolder:**____________________**DOB:**_________
4. **Secondary insurance:**________________**PolicyHolder:**____________________**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:**

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Therapist Name:____________________________