

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 _____