REGISTRATION FORM

Patient Information:

Patient's Name (Last, First, Middle) ____ **Date of Birth** ____ **Home Phone** ____

Street ____ **City** ____ **State** ____ **Zip Code** ____ **Patient's S.S. No.** ____

Name of Emergency Contact ____ **Telephone No.** ____ **Relationship** ____ **Patient's Cellphone** ____

Party Responsible for Fees:

Name (Last, First, Middle) ____ **Relationship** ____ **Date of Birth** ____ **Home Phone** ____

Street ____ **City** ____ **State** ____ **Zip Code** ____ **S.S. No.** ____

Employer ____ **Work Address** ____ **Cellphone** ____ **Work Phone** ____

Insurance Information **(please provide insurance card for copying):**

Name of Insurance Card Holder ____ **Social Security No.** ____ **Date of Birth** ____

Street ____ **City** ____ **State** ____ **Zip Code** ____

Employer ____ **Employer Phone** ____

FEE INFORMATION

If you will be using insurance, please provide your insurance card upon your first visit. We will ask that you pay the full cost of this first visit up front, either by check or credit card. After your deductible is met, we will require that you pay only your co-payment for each visit at the time of service. Please have your check already made out, so that we do not need to take session time for writing your check. If you are not using insurance, the entire fee will be due at the time of each appointment.

Our office will check on your specific insurance benefits and provide you that information. We will file insurance once monthly. Certain insurance companies (Blue Cross/Blue Shield, for example) will reimburse the patient only, while other insurance companies will reimburse the doctor's office. Please note your outstanding balance on the monthly statement you will receive. *IT IS STRONGLY ADVISED THAT YOU BECOME ACQUAINTED WITH YOUR SPECIFIC COVERAGE, SO THERE IS NO INTERFERENCE IN YOUR TREATMENT PROCESS.* IF AT ANY TIME DURING YOUR TREATMENT YOUR INSURANCE COVERAGE CHANGES, IT IS IMPERATIVE YOU LET OUR OFFICE KNOW.

Once your therapy schedule has been arranged between you and your doctor, it is important to keep all appointments. THERE WILL BE A FULL FEE CHARGE FOR ALL MISSED APPOINTMENTS NOT CANCELED AT LEAST 48 HOURS (TWO WORKING DAYS) IN ADVANCE. Your appointment time has been reserved for you and cannot be taken by another patient on short notice, so you will be financially responsible for that scheduled session.

I HAVE READ, AND I UNDERSTAND AND AGREE TO THE ABOVE TERMS OF THE OFFICE POLICY STATED ABOVE. I ALSO HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.

Signature of Patient/Parent ____ **Date** ____