REGISTRATION INFORMATION

Date:______________________ Home Phone:__________________ Cell Phone: _______________________

Patient:____
(Last Name) (First Name) (Initial)

Responsible Party (if a minor):____

Street Adress:____

City:____State:______________________Zip:_______________

Sex: ____ Male ____ Female Age: _____ Birthdate:_______________ Single____ Married____ Widowed ____Divorced____ Separated ______

Patient Employed By: ____

Business Address:____

Occupation:____ Business Phone:___________________________

Spouse (or responsible party) Employed By:____

Business Address:____

Occupation:____ Business Phone:___________________________

Purpose of Visit:____

Who is responsible for this account?_____________________________________ Relationship to Patient? ___________________

Social Security #_________________________________ Spouse's Social Security #_________________________________

Do you have Medical Insurance? ____ No ____ Yes Is this related to an Injury or Auto Accident? ____ No ____ Yes

Name of Primary Insurer ____

Contract #____________________________ Group # ___________________________Subscriber #_____________________________

Name of Secondary Insurer (if any)____

Contract#____________________________ Group# ___________________________ Subscriber # _____________________________

I prefer to:
______ Pay my balance in full at time of service ______ Pay my balance in full upon receipt of first statement ______ Make payment arrangements prior to services being rendered

In Case of Emergency, Who should be notified?
Name:______________________________________ Relationship: _______________________ Phone:_____________________

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf on myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____________________________ hereby authorize____
Name of Insured Name of Insurance Company

To pay and herby assign directly to Therapy Unlimited , all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Therapy Unlimited, LLC will be credited to my account, in accordance with the above said assignment.

Signature: ____ Date:________________________________