Therapy One REGISTRATION FORM

Please Print

1 PATIENT INFORMATION

Date: Family Doctor/PCP:

SS#	Last Name	First	Middle	Age

Street Address:	City:	State:	Zip:
Mailing Address (If different):	**City:**	**State:**	**Zip:**

Home Phone	Cell Phone	Birth Date:	Sex:			
( )	( )		M	F		Single
						Married

Employer:	Employer Address:	Employer Phone:

2. PATIENT CALL BACK INFORMATION

Therapy One uses an automated call back system to remind our patients of their next appointment. Please indicate if your prefer to have a voice or text message reminder and please proivde the appropriate cell phone number that will receive the text message or home number if you prefer a voice call back.

I prefer a: ☐ Voice Messsage ☐ Text Message

Please call or text my: ☐ Home Phone ☐ Cell Phone (provide the appropriate number above)

3 Billing Information

Person Responsible for Bill: ☐Self ☐Parent/Guardian* ☐Other

*Parent/Guardian Name: _____.

Address (if different from patient): _____ Phone: _____.

Parent/Guardian Employer: _____ Phone: _____.

4 INSURANCE INFORMATION

(Please fill out information below. Receptionist will also need to copy the front and back of your insurance card.)

Name of Primary Insurance:

Subscriber's Name:	Subscriber's SS	Date of Birth	Group #	Policy #

Subscriber's Address/Phone (*If different from pt):*

Subscriber's Employer:

Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other:

Name of Secondary Insurance (if applicable):

Subscriber's Name:	Subscriber's SS	Date of Birth	Group #	Policy #

Subscriber's Address/Phone (*If different from pt):*

Subscriber's Employer:

Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other:

5 EMERGENCY CONTACT

Name: _____ **Phone *(home/work/cell):*** _____.

6. AUTHOIRZATION OF PAYMENT AND MEDICAL RELEASE

I acknowledge that the above information is true to the best of my knowledge. I authorize Therapy One to treat as necessary. I authorize payments of medical benefits be made directly to Therapy One. I agree to payy all applicable co-payments, co-insurance and deductibles. I also agree to pay for treatments rendered that is not covered by my insurer or other payers.

I authorize the release of records neccessary to assis in the reimbursment of benefetis. I authorize the release of recors to any other entitity, including, but not limited to, physicians, hospitals, or other healthcare providers, as neded to provide with the most appropriate care.
The signiture below shall sufice for all insurance forms on a contributing b asis.

X_____. _____.

RESPONSIBLE PARTY DATE

7 NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have received/been offered a copy of Therapy One's Privacy Practices.

X_____. _____.

RESPONSIBLE PARTY DATE