Children's Therapy Connection Patient Registration

Please fill out every line as accurately as possible. Do not leave any lines blank.

Patient Name: _____
(First) (Middle Initial) (Last)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Sex: Male Female**

Date of Birth: _____ **Social Security #:** _____

Parent/Guardian Name: _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

Referring Doctor: _____ **Date of Injury/Onset:** _____

Financial / Insurance Information: Please allow us to make copies of all of your insurance cards as well as your driver's license. The following information is necessary to process insurance claims.

Primary Insurance: _____

Policy Holder's Name: _____

Date of Birth: _____ **Social Security #:** _____

Secondary Insurance: _____

Policy Holder's Name: _____

Date of Birth: _____ **Social Security #:** _____

I authorize the release of any medical information necessary to process my claims. I hereby authorize Children's Therapy Connection to apply for benefits on my behalf for services rendered by them. I request that payment from my insurance company be made directly to Children's Therapy Connection. I permit a copy of the authorization to be used in place of the original. My insurance company or I may revoke this authorization at any time. This revocation must be submitted to Children's Therapy Connection in writing.

I am responsible for all copays/coinsurances, which are due and payable at the time services are rendered, as well as deductible amounts. If for some reason insurance denies my claims, I am responsible for these balances as well. If further action ever becomes necessary and is taken in order to collect any delinquent balance due on my account, I agree to pay for all collection, attorney, and court fees incurred by Children's Therapy Connection for the collection of any and all balances due on my account. I am aware that 1.5% interest is assessed on all account balances each month.

By my signature below, I acknowledge I have read and understand the preceding statements regarding my insurance, as well as my financial responsibilities, including if insurance does not pay. I am responsible for any outstanding balance on my account.

Parent/Guardian Signature: _____ **Date:** _____