AFFILIATED
THERAPY GROUP PRACTICE

PATIENT REGISTRATION

PATIENT INFORMATION:

FIRST NAME	MIDDLE NAME	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH		
	MONTH	DAY	YEAR

GENDER	
MALE	FEMALE

MARITAL STATUS		
SINGLE	MARRIED	OTHER

ADDRESS:

STREET		
CITY	STATE	ZIP CODE

CONTACT

CELL PHONE	HOME PHONE

EMAIL

Preferred Method of Contact: Cellphone:Text/Voice, Work, Home Phone or Email

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER

MEDICAL RECORDS RELEASE AUTHORIZATION

NAME	RELATIONSHIP	PHONE NUMBER

EMPLOYER INFORMATION

EMPLOYER NAME

PLEASE FILL OUT IF WE DON'T HAVE A COPY OF INSURANCE CARDS AND DRIVERS LICENSE ON FILE.

DRIVERS LICENSE

NUMBER	STATE	DATE OF ISSUE - DATE EXPIRE

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY		
CLAIMS MAILING ADDRESS		
FULL NAME OF INSURED		
ID NUMBER		
GROUP NUMBER		
PHONE IN THE BACK		
Date of Birth of **GUARANTOR**		
SSN of **GUARANTOR**		

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, **not the insurance company**. Therefore, Payment for treatment is your responsibility, insurance benefits are verified at the time of your visit and are **not a guarantee of payment.**

Please read and sign the following:

1) I authorize this office to release or receive any information necessary to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this clinic of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my therapist for which these fees are payable.
5) If you are a worker's compensation patient, your worker's compensation carrier is responsible.
6) If your employer is self insured, you will be responsible for any remaining balance.

I understand that I am directly and fully financially responsible to this clinic for charges not covered by my insurance. I further understand that such payment is not contingent or any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my therapy bill directly.

I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filling fees as well as reasonable attorney's fees.

There will be a $25.00 charge on all returned checks.

A photo static copy of these authorizations and agreements shall be as valid as the original.

I acknowledge that no guarantees have been made as to the results of medical treatment hereby authorized.

I understand that I am fully responsible for all articles (money, radios, jewelry, dentures, eyeglasses, etc) and clothing which I retain in my possession.

I hereby authorize Affiliated Therapy Group Practice, Inc. to carry out all procedures ordered by my physician and I give you my consent for treatment.

I have been offered a paper copy of the "Notice of Privacy Practices" during the admission/registration process. _____ Initials.

Signature/Parent's Signature if Minor _____

Date _____