



Patient Registration Form

Name_____	Sex_____	Marital Status_____
Address_____	Spouse's Name_____	(or policy holder, if patient is a minor)
City_____ State___ Zip_____	Spouse's Employer_____	
Date of Birth_____ Age_____	Primary Insurance Carrier_____	
Home Phone_____	Do You Have A Secondary Insurance?_____	
Cell Phone_____	Name of Secondary Carrier_____	
Work Phone_____	Is This Work Or Auto Accident Related?_____	
Employer's Name_____	Claim#_____ Phone_____	
Address_____	Doctor Referring You_____	
City_____ State___ Zip_____	Friend/Relative Referring You_____	

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to:

The Therapy Institute, LLC.

The Therapy Institute bills according to your insurance guidelines. Your health insurance information will be kept on file in case of notice of dispute or rejection. You will be notified of any copays, deductibles or any limitations.

I understand I am financially responsible for any balance not covered by my insurance carrier.
A copy of this signature is as valid as the original.

Signature

Date