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

Patient Name: _____ Date: _____

Medical History

Please list all of your relevant surgeries:

_____

_____

_____

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_____

Please list any current medications you are taking:

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HIPAA NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have received/been offered the Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe relationship to patient:

_____

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

(Optional)

My protected health information may be disclosed to:

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that, as set forth in The Therapy institute, LLC's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:
The Therapy Institute, LLC
1660 Haslett Road, Suite 4
Haslett, MI 48840
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority