Advanced Therapy Care

Therapy Services for Adults and Children

New Patient Registration Form

Date: _____ **Referring Physician:** _____

PATIENT INFORMATION					
Patient's Last Name:	**First:**	**Initial:**	**Parent or Guardian Name:**		
Address:		**City:**	**Zip Code:**		
Home Phone:	**Cell Phone:**	**Birthdate:**	**Email Address:**	**I want email reminders** ☐ Yes ☐ No	
Emergency Contact:		**Emergency Contact Phone:**			

INSURANCE INFORMATION			
Is this patient covered by insurance? ☐ Yes ☐ No	**Please indicate primary insurance:** ☐ Tricare ☐ Blue Cross ☐ Regence ☐ Medicaid ☐ Other		
Subscriber Name:	**Birthdate:**	**Address (if different):**	
Employer:	**Guarantor SSN:**	**City:**	**Zip Code:**
Subscriber ID No.:	**Subscriber Group No.:**	**Patient's relationship to Subscriber?** ☐ Self ☐ Child ☐ Spouse	

SECONDARY INSURANCE INFORMATION		
Is this patient covered by a secondary insurance? ☐ Yes ☐ No	**Insurance Carrier Name:**	**Subscriber ID No.:**

CONSENT & FINANCIAL AGREEMENT

I understand that I am responsible for all costs **NOT** covered by my insurance. I also understand that I am responsible for any and all charges denied by my insurance company that are deemed not medically necessary. If my account balance is not paid in full or not set up under a payment plan, there will be a late fee of $3.00 per charge. If my account becomes delinquent, it will be forwarded to collections. I authorize my insurance benefits to be paid directly to Advanced Therapy Care. I also authorize Advanced Therapy Care to release any information required to process my claims directly to my insurance company.

I acknowledge that I have received and/or read the Health Information Privacy Act _____

_____ _____

Patient or Parent/Guardian Signature **Date**