NEW CLIENT REGISTRATION

PATIENT NAME:

Last____ First______________________________ M.I._____
SS#______________________________ DOB___________________ Sex__M__F Marital Status__S__M__D
Street Address____
City, State, Zip____
Home Phone_______________________________________ O.K. to leave a message?________________
Work Phone_______________________________________ O.K. to leave a message?________________
Cell Phone____ O.K. to leave a message?________________
Email Address____
Preferred method of communication______________________________ O.K. to leave a message?______
Emergency Contact_______________________________________ Phone_____________________________
Relationship to you_______________________________________
Referring Doctor_________________________________ Primary Doctor_____________________________

INSURANCE INFORMATION:

Primary Insurance____ Phone_____________________
Subscriber's Last Name___________________________________ First_________________________ M.I.___
Relationship to Patient________________________________ Subscriber Employer____________________
Subscriber SS#______________________________ DOB______________________ Sex __M__F
Insurance I.D.#____ Group #_________________________
Insurance Billing Address____

PATIENT OR AUTHORIZED PERSON'S AGREEMENT:

I authorize treatment for the above-named patient and understand and agree that I am responsible for all charges incurred thereof. I authorize the release of any medical information necessary to process my insurance claim and hereby request payment directly to O.T. Plus, Inc. for services rendered. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice. If your account should become delinquent, and if O.T. Plus, Inc. must refer your account to a collection agency or attorney for collection, you shall be responsible for all such costs of collection, plus all additional costs, including reasonable attorney fees and court costs incurred by O.T. Plus, Inc. as a result of such collection efforts.

A copy of the HIPAA Regulation is posted in the O.T. Plus office and on www.otplus.org I understand that a copy will be provided to me upon request.

Signature____ Date____________________________

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