CHILDREN'S THERAPY
of Woodinville, P.L.L.C.

PATIENT REGISTRATION FORM

Patient Name: (Last – First – Initial)		Date Of Birth:	Sex: M __ F__
Address:	City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Emergency Phone: ( )	Parent's Names:

Insurance Company:		Effective Date of Insurance:	
Subscriber Name: (Last – First – Initial)		Subscriber ID#:	Plan/Group #:
Subscriber's Employer:	Subscriber Birthdate:	Subscriber Social Security #:	Sex: M ___ F ___
Relationship to Patient:	Copay Amount:	Home Phone: ( )	Work Phone: ( )

Insurance Company or Funding Source:		Subscriber Name: (Last – First – Initial):
Subscriber ID#:	Plan/Group #:	Subscriber Birthdate:

Primary Care Doctor:	Address:	Phone:
Primary Referral Concern/Diagnosis		Code:

I authorize treatment of the person named above and agree to pay all fees for such treatment. I authorize Children's Therapy of Woodinville or the therapist to release any information to process medical claims. I also authorize my insurance benefits to be paid directly to the clinic. I further understand that I am responsible for charges associated with medical services and agree to pay those charges which are my responsibility. I also understand that a $35 fee (RCW62A.3-515&520) for returned checks will be charged. Any unpaid balance over 60 days is subject to a 1.5% monthly finance charge (18% per annum). An unpaid patient balance over 90 days may be sent to collection.

Signature (Parent or Guardian)	Date: