chapman & associates
therapy solutions, llc.

PATIENT REGISTRATION & CONSENT FORM

1. Patient Information

Patient Name:_____ DOB:_____ Age:_____ Sex:_____

Address:_____ City:_____ ST:_____ ZIP:_____

Pediatrician/PCP:_____ Phone: ( ) _____-_____ Fax: ( )_____-_____

PCP Address:_____ City:_____ ST:_____ ZIP:_____

2. Guarantor/Responsible Party

Legal Name:_____ DOB:_____ SS#_____-____-_____

Address:_____ City:_____ ST:_____ ZIP:_____

Home Phone #: ( ) _____-_____ Work Phone #: ( ) _____-_____ Cell Phone #: ( ) _____-_____

Email Address:_____ Relationship to Patient:_____

3. Primary Insurance Policy

Insurance Company:_____ Insurance Company Phone #: ( ) _____-_____

Claims Address:_____ City:_____ ST:_____ ZIP:_____

Primary Policyholder:_____ DOB:_____ Relation to Patient:_____

Policy/Member #:_____ Group #:_____ Group/Employer:_____

4. Secondary Insurance Policy

Insurance Company:_____ Insurance Company Phone #: ( ) _____-_____

Claims Address:_____ City:_____ ST:_____ ZIP:_____

Primary Policyholder:_____ DOB:_____ Relation to Patient:_____

Policy/Member #:_____ Group #:_____ Group/Employer:_____

How did you hear about Chapman & Associates Therapy Solutions? _____

5. Consent and Release

CONSENT TO TREATMENT: I hereby grant my authorization and consent to Chapman & Associates Therapy Solutions for evaluation and treatment of the above named patient for developmental delays or any other medically necessary condition requiring speech, occupational and/or physical therapy, and certify that no guarantee of assurance has been made as to the results obtained under the care of Chapman & Associates Therapy Solutions.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I authorize Chapman & Associates Therapy Solutions to release any medical information in connection with these services to health insurance, physicians or any other third-party involved in the ongoing treatment of this patient.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I hereby assign all medical and/or therapy benefits to which I am entitled, including government sponsored programs, private insurance and other health plans to Chapman & Associates Therapy Solutions. The assignment shall remain in effect until revoked by me in writing. I hereby authorize said Assignee to release all information necessary to secure the payment which is to be issued to Chapman & Associates Therapy Solutions for their services as described herein. I understand that I am financially responsible for all charges whether or not paid by said insurance. I promise to pay Chapman & Associates Therapy Solutions all charges, copayments, deductibles and coinsurance amounts for services rendered to or on behalf of the patient upon receipt of invoice from Chapman & Associates Therapy Solutions. I understand that I will be charged 18% annual interest on any unpaid balance that is 31 days or more past due. I further agree to pay all collection costs and attorney fees should the account become delinquent and be referred to a collection agency.

BCBS POLICYHOLDERS: I agree to immediately forward to Chapman & Associates Therapy Solutions all information and payments sent by BCBS to policyholder. I understand that failing to immediately forward all information and payments from BCBS to Chapman & Associates could increase my financial responsibility due to claims being processed incorrectly or for any other reason. The Assignment of Benefits and Financial Responsibility Consent above also applies to BCBS policyholders.

CANCELLATION/NO SHOW POLICY: I understand Chapman & Associates Therapy Solutions will charge me $25 for missed visits and/or cancellations within 24 hrs. I also understand that Chapman & Associates reserves the right to terminate therapy services provided to the above named patient after two (2) missed scheduled appointments and/or 3 cancellations within a 90 day period.

By signing below you are agreeing to all terms and conditions of this agreement.

Signature:_____ Print Name:_____ Date:_____