LANGSTON
Pediatric Therapy
HELPING SMALL HANDS DO BIG THINGS

Patient Registration Form

Demographic Information

Patient Name: _____ M □ F □ Date of Birth:_____

Address: _____ Phone (H):_____

_____ Phone (C):_____

Parent Names: _____ Phone (W):_____

_____ Phone (W):_____

Email Address: _____

How did you hear about us? _____

Patient Doctor Information

Doctor's Name: _____ Phone #:_____

Doctors Address: _____ Fax #:_____

_____

Insurance Information

Insurance Co. Name:_____ Insured's Employer:_____

Policy Holders Name:_____

Date of Birth:_____ SS# _____

Relationship to Patient:_____

Insurance ID #:_____ Group #: _____

RELEASE OF INFORMATION, AUTHORIZATION OF BENIFITS, FINANCIAL POLICY

* I authorize Langston Pediatric Therapy to release to my insurance company or its representatives, any information regarding my diagnosis or records of any treatment or evaluation rendered to me that is required to process my claim for benefits.
* I authorize and request that my insurance company pay directly to Langston Pediatric Therapy (Laura Langston MOT, OTR/L) the amount due in pending claims for therapeutic treatments and services provided, by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.
* I understand that I am directly responsible for services rendered which are not paid by insurance. Refer to attached Billing Policy attached for full information.

By signing this form you acknowledge that you have read and understand the contents of this form, the billing policy form, and the Notice of Privacy Practices Form. I certify that to the best of my knowledge, the information provided and contained on this form is true and accurate. I will notify Langston Pediatric Therapy of any changes to any information.

_____ _____

Patient Signature Date