Choice Therapy
Physical · Occupational · Speech

3835 Supreme Ct. NW Suite 2
Bemidji, MN 56601
Phone: 218.444.8280
Fax: 218.444.8337
www.ChoiceTherapy1.com

REGISTRATION FORM

Date: _____
Last Name: _____ First Name: _____M.I. _____
Address: _____ Apt. or PO Box: _____
City: _____ State: _____
Zip: _____ Email: _____
SSN: _____ DOB: _____

Phone Numbers:
Home Phone: _____
Work Phone: _____
Mobile Phone: _____

Emergency Contact:
Last Name: _____ First Name: _____
Phone: _____ Relationship: _____

Problem:
Problem Description: _____
Referred by: _____ Referral Information: _____
Date of Onset: _____

_____ **PRIVATE PAY OPTION** (If you have Medicare, MA, or a state health plan, you are not eligible)
* Consider Private Pay if:
- You have a high deductible medical plan & you have NOT met your deductible
- You do not have insurance
* Price:
- $110 initial visit
- $85 per visit for follow-ups

OR

_____ **BILL MY INSURANCE COMPANY** (Once charges have been submitted to insurance the private pay option is not available)

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INSURANCE INFORMATION:
*NOT APPLICABLE WITH PRIVATE PAY OPTION

Primary Insurance:
Insurance: _____ ID Number: _____
Group Number: _____ Phone #: _____
(Copays are due at the date of service)

Subscriber Information:
Subscriber Name: _____ Subscriber DOB: _____
Subscriber Relationship to Patient: _____

Secondary Insurance:
Insurance: _____ ID Number: _____
Group Number: _____ Phone #: _____
(Copays are due at the date of service)

Subscriber Information:
Subscriber Name: _____ Subscriber DOB: _____
Subscriber Relationship to Patient: _____

Workers Compensation Insurance:
Insurance: _____ Claim #: _____
Date of Injury: ____/____/____
Adjustor Name: _____ Phone #: _____
Employer: _____ Phone #: _____
Address: _____ City/State/Zip: _____

Liability/Motor Vehicle Insurance:
Insurance: _____ Claim #: _____
Date of Injury: ____/____/____ State Injury Occurred: _____
Adjustor Name: _____ Phone #: _____

Patient or Guardian Agreement: (Please Check)
_____ I authorize the release of information requested by my insurance plan for payment or referring physician.
_____ I understand that I am responsible for any balance due.
_____ I agree to comply with the terms and conditions as outlined in the Patient Registration form.
_____ I consent Choice Therapy to render appropriate treatment as prescribed by my physician.

Signature of Patient or Guardian: _____ Date: ____/____/____

Notice of Privacy Practices: (Please Check)
_____ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature of Patient or Guardian: _____ Date: ____/____/____