Associated Christian Therapy Services, Inc

Fee: _____

CLIENT REGISTRATION

Therapist: _____

PLEASE COMPLETE THIS FORM & PRINT CLEARLY

Dx: _____

CLIENT INFORMATION

Date: _____ **Gender**: M F **Birthday** (Mo, Day, Yr): _____ **Age**: _____

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Number, Apt., & Street Address: _____

City: _____ **State**: _____ **Zip**: _____ **Marital Status**: S M W D

Social Security #: _____ **Employer**: _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #**:_____

PARTY RESPONSIBLE FOR PAYMENT (INSURED PARTY- SPOUSE, PARENT, OTHERt)
IF DIFFERENT THAN PATIENT

Last Name: _____ **First Name**: _____ **Middle Initial**: _____ **DOB:** _____

Number, Apt., & Street Address: _____

City: _____ **State**: _____ **Zip**: _____ **Phone #**: _____

Social Security #: _____ **Relationship to Patient**: _____

Employer: _____ Position: _____ **Work #**: _____

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU
(EMERGENCY CONTACT INFORMATION)

Last Name: _____ **First Name**: _____ **Relationship**: _____

Number, Apt., & Street Address: _____

City: _____ **State**: _____ **Zip**: _____ **Phone #:** _____

INSURANCE INFORMATION

PRIVATE HEALTH INSURANCE- PRIMARY

Insured's Name: _____

Relationship to Pt.: _____

SS#: _____ **Ins. ID #:** _____

Ins. Company Name: _____

PRIVATE HEALTH INSURANCE- SECONDARY

Insured's Name: _____

Relationship to Pt.: _____

SS#: _____ **Ins. ID #:** _____

Ins. Company Name: _____

ASSIGNMENT OF BENEFITS

I hereby authorize ASSOCIATED CHRISTIAN THERAPY SERVICES to furnish information to insurance carriers concerning this treatment. I hereby irrevocably assign to the therapist all payments for medical services rendered and ALL MAJOR MEDICAL BENEFITS.

I understand that I am financially responsible for all charges regardless of any insurance claims

Sign Here: _____

Referred By: ☐ FRIEND ☐ RELATIVE ☐ INSURANCE COMPANY ☐ INTERNET ☐ YELLOW PAGES

☐ FORMER OR CURRENT CLIENT ☐ OTHER: _____