"I CAN" Pediatric Therapies, LLC

697 Edgewood Road Wilkesboro, NC 28697
Phone:336.667.1555 Fax:336.667.2088

206 Cooper Street Statesville, NC 28677
Phone: 704.775.4683 Fax:704.775.4936

Patient Registration Sheet

PATIENT INFORMATION

Patient Last Name: _____ First Name:_____ MI:_____

Date of Birth:_____ SSN: _____ Sex: M F

Address: _____

City: _____ State:_____ Zip Code:_____

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

PARENT GUARDIAN INFORMATION

Last Name: _____ First Name:_____MI:_____

Relationship to Child:_____ Date of Birth:_____

Address (If different from above) _____ City: _____ State:_____

Zip Code:_____

Employer: _____ Telephone: (_____) _____

PARENT GUARDIAN INFORMATION

Last Name: _____ First Name:_____MI:_____

Relationship to Child:_____ Date of Birth:_____

Address: (if different from above)_____ City: _____ State:_____

Zip Code:_____

Employer: _____ Telephone: (_____) _____

EMERGENCY CONTACT

Name: _____

Relationship: _____ Telephone: (_____) _____

Acceptant of Financial Responsibility: I understand that "I CAN" Pediatric Therapies will bill my insurance directly, but that I am responsible for deductible, co-payments, coinsurance and other charges not covered by my insurance provider at time services are rendered. **Authorization to Release Information:** I hereby authorize "I CAN" Pediatric Therapies, LLC to release any information acquired in the course of my child's evaluation or treatment to insurance carriers, attorneys, or agencies involved in the payment of my account. **Assignment of Benefits:** I hereby authorize payment of medical benefits directly to "I CAN" Pediatric Therapies, LLC. **HIPPA Policy:** I acknowledge that I have been informed of the HIPPA Privacy Policy available at: www.icanpediatrictherapies.com or hard copy available per request.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Release of Information

Due to privacy policy, we are unable to release information to anyone other than the child's guardian/parent. If you would like your therapist to discuss your child's progress and share information with other individuals/professionals outside of "I Can" Pediatric Therapies, LLC please list their names and contact information below. I agree that information regarding my child's care may be released to/received from the following people/agencies:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Patient's Name Date of Birth

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Insurance Verification

Patient Primary Plan Name:_____

Patient Policy Number: _____ Patient Group Number: _____

Policy Holder Name: _____ Policy Holder's Date of Birth:_____

Patient Secondary Plan Name: _____

Patient Policy Number: _____ Patient Group Number: _____

Policy Holder Name: _____ Policy Holder's Date of Birth:_____

I have read and agree that the above information is correct. I also agree that my insurance benefits have been explained to me, but ultimately, I am responsible for the bill if insurance does not pay.

Signature:_____ Print Name:_____

Witness: _____ Date: _____

For Office Use Only:

Effective Date: _____ In/Out of Network:_____

Pre-Authorization Required: _____

CoPay: _____ CoInsurance: _____ Deduct: _____ Met:_____

No. of Visits/Calander:_____ Auth#: _____ Visits Authorized: _____

Notes: _____

_____

Verified By:_____