Skagit OT Studio

Patient Registration

Client's Name:_____(M/F) Birth Date:_____
Parents/Guardian:_____
Address:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Email:_____School/Daycare:_____Grade:____
Clinical Diagnosis:_____Referring Diagnosis_____
Physician:_____ Physician Phone:_____

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Primary Insurance Company:_____
Billing Address:_____
Insurance ID:_____Group #:_____
Insured Name:_____Relationship to Client:_____

Secondary Insurance Company:_____
Billing Address:_____
Insurance ID:_____Group #:_____
Insured Name:_____Relationship to Client:_____

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Guarantor (Person Responsible for Payment)
Full Name:_____(M/F) Birth Date:_____
Address:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Relationship to Patient:_____Relationship to Insured:_____

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Release of Benefits and Information

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment of services. I authorize Skagit OT Studio to be my personal representative, which allows Skagit OT Studio to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100 percent of my benefits within 90 days of any and all appeals or requests for information. I also agree that any fines levied against my insurance company will be paid to Skagit OT Studio for acting as my personal representative.

_____ _____
Signature of Parent or Legal Guardian Relationship to Client

_____ _____
Printed Name of Parent or Guardian Date