Registration Form
Welcome to Advanced Pediatric Therapies!

Child's Name(s)

Last Name First Name MI Nickname Birth Date Sex

____ ___/___/___ M F

Child's Address:

____

Street City State Zip Code

Primary Parent/Guardian:

Name:_______________________________________

☐Male ☐Female

MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Other

D.O.B:____/____/____

Address:_____________________________________

Cell #:_________________ Home #:_________________

Work #:_________________

Email_______________________________________

Occupation:__________________________________

Secondary Parent/Guardian:

Name:_______________________________________

☐Male ☐Female

MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Other

D.O.B:____/____/____

Address:_____________________________________

Cell #:_________________ Home #:_________________

Work #:_________________

Email_______________________________________

Occupation:__________________________________

Other Parent/Guardians/Emergency Contacts:

Name:______________________________________ Cell Phone:______________________________________

Relationship to child ________________________________

I give permission to APT to leave a phone message with information regarding my child's medical care at the number(s) listed above. Initial_____

Billing Information: ☐PRIVATE PAY (NO INSURANCE)

☐INSURANCE (PRIMARY) EFF. DATE:_____________

INSURANCE CO.______________________________

POLICY HOLDER__________________________D.O.B._______

MEMBER NUMBER:___________________________________

GROUP NUMBER:____________________________________

☐INSURANCE (SECONDARY) EFF. DATE:_____________

INSURANCE CO.______________________________

POLICY HOLDER__________________________D.O.B._______

MEMBER NUMBER:___________________________________

GROUP NUMBER:____________________________________

Who referred you to our office? ____

Text Message Consent Notice:

By providing the below cell number and carrier I give consent to APT to send text reminders to my mobile telephone. These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to schedule an appointment. Should I not be able to keep an appointment I will call the office to cancel. All clients have the right to change their minds and have this service stopped by calling the office. If you change your mobile number please inform us so that we can update our records.

Cell # ______________________ Mobile Carrier: (Verizon, AT&T, Sprint, T-mobile, etc.) ____________________

Name printed:__________________________ Signature: _______________________ Date: ____________

E-mail Consent Notice:

I acknowledge that Advanced Pediatric Therapies Email Informed Consent Notice has been made available to me. A paper copy of this notice will be provided at my request. This notice is also displayed on Advanced Pediatric Therapies website www.advancedpediatrictherapies.com.

I have read the risks factors and conditions for the use of e-mail and understand Advanced Pediatric Therapies cannot guarantee privacy for e-mail communications over the internet. I hereby consent to the use of email for communications to and from Advanced Pediatric Therapies regarding my medical treatment.

_____ Yes _____ No

____ X_______________________________________ ____________

Patient or Personal Representative's Name Printed | Patient or Personal Representative's Signature | Date

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CONSENT FOR TREATMENT: I hereby consent to and authorize the therapist and any assistants or associates to conduct such evaluations and treatments the therapist deems necessary and appropriate. I also authorize personnel from the clinic to provide routine services requested by the therapist.

FINANCIAL RESPONSIBILITY: For and in consideration of the treatment to the patient, I promise to pay all charges for services rendered to or on behalf of the patient. APT will bill my insurance when applicable. If the assigned insurance denies payment, I promise to pay the balance due upon notification. I am responsible for paying my deductible, copay, and/or coinsurance at the time of service. Any unpaid balance that is over 60 days old will be referred to Collections for accounts receivable assistance. I will bear the cost of collection and /or court costs and reasonable legal fees should this be required. IF at any time my balance due becomes greater than $250, then I understand that my child may not be seen until a payment arrangement has been made.

INSURANCE AUTHORIZATIONS: I understand that in all cases the services being provided by APT may exceed the amount of time (or number of sessions) my insurance company will reimburse. I am solely responsible for keeping track of my number of authorized visits and my authorization period. I understand APT cannot track that for me.

CANCELLATION NOTICE: If I do not give 24 hours cancellation notice I will be charged a minimal charge of $50/hour. Cancellations made within 2 hours of scheduled appointment may be charged the full rate/hour. If I cancel or no show 3 times per month, I may be asked to discontinue services or find another time slot that works better for me.

RELEASE OF INFORMATION: I authorize Advanced Pediatric Therapies to release any information necessary to process the claim. I also authorize Advanced Pediatric Therapies to submit claims for services rendered without obtaining my signature on each claim.

ASSIGNMENT OF BENEFITS: I authorize my insurance/benefits carrier(s) to remit payment of benefits for any claim to Advanced Pediatric Therapies. I understand that any ineligible /not covered charges are my responsibility.

SIGNATURE:_______________________________**PRINT NAME:**__________________________________**DATE:**_______________