Therapeutic Services, LLC
Speech & Language Therapy

NEW CLIENT REGISTRATION FORM

Today's Date: _____ Child's Name: _____

Date of Birth: _____ Age:_____ Gender: M / F Nick Name_____

Address: _____

City: _____ State: _____ Zip: _____

PARENT /LEGAL GUARDIAN

Name: _____ Relationship to Client: _____

Marital Status: _____ Occupation: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email: _____ Languages: _____

Name: _____ Relationship to Client: _____

Marital Status: _____ Occupation: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email: _____ Languages: _____

EMERGENCY NOTIFICATION: If you will be leaving your child during the session, please provide a phone number to reach you in case of emergency _____

CLIENT'S PRIMARY PHYSICIAN

Physician Name: _____ Practice: _____

Address:_____ City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

INSURANCE

Primary Policyholder: _____ Relationship to Client: _____

Insurance Company: _____

Address:_____ City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

Policy Number: _____ Group Number: _____

EMERGENCY INFORMATION

Please list two people we may contact in case of an emergency:

Name: _____ Relationship to Client: _____

Contact Information: _____

Name: _____ Relationship to Client: _____

Contact Information: _____

ALLERGY/MEDICAL ALERT

Diagnosis: _____

Allergies: _____

Medications: _____

Medical Conditions: _____

Describe and provide emergency actions (e.g. EpiPen, seizure precautions, inhalers, latex allergies, special diet etc…)_____

_____

_____

RELEASE OF INFORMATION

I am aware of the client's diagnosis and wish to receive treatment from Therapeutic Services LLC. I permit its employees to treat the client in ways they judge are beneficial to the client. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Therapeutic Services LLC to release information, verbal and written, contained in the client's medical record, and other related information, to the client's insurance company, case manager, attorney, employers, related healthcare providers, assignees and/or beneficiaries and all other related persons as it is related to treatment.

I authorize Therapeutic Services LLC to obtain medical records and/or professional information from the client's physician(s) or other medical professional(s) as it relates to the client's treatment.

HIPPA: Notice of Privacy Practices

I understand that Therapeutic Services LLC "Notice of Privacy Practices" is available to me at any time as a printable PDF Document on their website @ www.therapeuticservicesllc.com: □Yes □No

I have received a paper copy of Therapeutic Services LLC's "Notice of Privacy Practices" during the registration process and will review it at my convenience. □Yes □No

I understand my rights contained in the notice, and by way of my signature, I provide Therapeutic Services LLC with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the "Notice of Privacy Practices."

AUTHORIZATION

All information provided herein is true and correct. The signature below certifies that I have read and understand the above information.

_____
Client's Name

_____ _____ _____
Parent, Guardian, or Responsible Party Signature Relationship Date

_____
Parent, Guardian, or Responsible Party Name