PATIENT REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

PATIENT NAME: ______________________________ SEX: ______ DOB: ____________
LAST FIRST MI M/F MO DAY YR

ADDRESS: ______________________________ CITY ____________ STATE ______ ZIP ________

REFERRING PHYSICIAN NAME/PHONE: ______________________________

PRIMARY PHYSICIAN NAME/PHONE: ______________________________

ALLERGIES/PRECAUTIONS:

Does your child have any allergies, seizures or precautions? If so, please list and describe:

____

RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN)

NAME: ______________________________ DOB: ____________
LAST FIRST MI MO DAY YR

RELATION TO PATIENT: ______________________________

ADDRESS: ______________________________ CITY ____________ STATE ______ ZIP ________

PHONE: ____________________ EMAIL ADDRESS: ____________________

PREFERRED METHOD OF COMMUNICATION: Phone Email Mail

NAME: ______________________________ DOB: ____________
LAST FIRST MI MO DAY YR

RELATION TO PATIENT: ______________________________

ADDRESS: ______________________________ CITY ____________ STATE ______ ZIP ________

PHONE: ____________________ EMAIL ADDRESS: ____________________

PREFERRED METHOD OF COMMUNICATION: Phone Email Mail

INSURANCE

PRIMARY INSURANCE: ____________________ INSURANCE PHONE: ____________________

POLICY HOLDER: ____________________ EMPLOYER: ____________________
LAST FIRST MI

RELATION TO PATIENT: ______________________________ DOB: ____________
MO DAY YR

POLICY NUMBERS: ______________________________
(ID #) (GROUP #)

SECONDARY INSURANCE: ____________________ INSURANCE PHONE: ____________________

POLICY HOLDER: ____________________ EMPLOYER: ____________________
LAST FIRST MI

RELATION TO PATIENT: ______________________________ DOB: ____________
MO DAY YR

POLICY NUMBERS: ______________________________
(ID #) (GROUP #)

RELEASE OF INFORMATION:

I authorize the exchange of Protected Health Information between Kids Place Therapy Services, LLC, and the specified individuals listed below:

DOCTOR/CLINIC: ______________________________ PHONE#: ______________

PRESCHOOL/SCHOOL DISTRICT: ______________________________ PHONE#: ______________

OTHER: ______________________________ PHONE#: ______________

OTHER: ______________________________ PHONE#: ______________

OTHER CONTACTS:

Please list other individuals who are involved in taking care of the patient, such as caregiver and/or relative other than guardian, with whom you authorize Kids Place Therapy Services, LLC to discuss/exchange information regarding the patient's treatment.

NAME: ______________________________ RELATION TO PATIENT: ______________
LAST FIRST MI

PHONE: ______________________

NAME: ______________________________ RELATION TO PATIENT: ______________
LAST FIRST MI

PHONE: ______________________

AUTHORIZATIONS and ACKNOWLEDGEMENTS: (*Please Initial Each Statement*)

_______ 1 I have received the Notice of Privacy Practices from Kids Place Therapy Services, LLC.

_______ 2. I have received the Patient Service Agreement from Kids Place Therapy Services, LLC.

_______ 3. Kids Place Therapy Services, LLC occasionally photographs/videotapes for lecture, training, webpage and/or marketing. I give Kids Place Therapy Services, LLC permission to photograph/videotape my child for the following purposes:

Please circle "yes" or "no" for each of the purposes.

Professional Lecture/Training: Yes/No Webpage: Yes/No Marketing Materials: Yes/No

_______ 4. I hereby authorize KIDS PLACE THERAPY SERVICES, LLC to furnish information concerning treatments to INSURANCE CARRIERS, PHYSICIANS, and THERAPISTS AND/OR OTHER PERSONNEL who are involved in taking care of the patient. I authorize payment of any medical benefits to KIDS PLACE THERAPY SERVICES, LLC. I certify that the above information is correct and that I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED. I permit a copy of this authorization to be used in place of the original.

_______ 5. I hereby give permission for my child, ______________________ to be treated by Kids Place Therapy Services, LLC for therapy services. Therapy services have been explained to me, and I understand this treatment and explanation and approve of said treatment.

SIGNATURE: ______________________________ DATE: ______________
Parent/Legal Guardian

FUNCTIONS AND ACTIVITIES/RELEASE OF LIABILITY:

I understand that my child's participation in therapy and activities with Kids Place Therapy Services, LLC is by Parent/Guardian choice. I acknowledge there are certain risks associated with these activities, including physical injury and/or illness. I acknowledge that there may be risks I am unaware of inherent in these activities or presence on or about our offices.

By signing this Permission and Waiver Form as the Parent/Guardian, I expressly assume all risks to my child and me that arise from participation in these activities or presence on or about our offices, whether such risks are known or unknown to me at this time. I release and further agree to indemnify and hold harmless Kids Place Therapy Services LLC, its employees, contractors and volunteers from any and all claims my child or I may have against them as a result of injury or illness incurred during the course of participation in therapy activities or presence on or about our offices. This release of liability is intended to cover all claims that members of my child's or my family's estate, heirs, representatives or assigns may have against Kids Place Therapy Services LLC, its employees, contractors and volunteers.

SIGNATURE: ______________________________ DATE: ______________
Parent/Legal Guardian