Custom Fit Therapies

Julie A. Venn, LMP, MLD/CDT Massage Therapist

REGISTRATION FORM

Name: _____Date: _____

Address: _____ Phone – day: _____

City: _____State:_____ Zip: _____ Phone – eve:_____

Birthday: _____ Age: _____ Sex: M or F Social Security #:_____

Occupation: _____E-mail_____

Employer: _____ Phone: _____

Insurance Company: _____ Group Number: _____

Subscriber ID#:_____ Subscriber Name: _____

Secondary Insurance Company: _____ Group Number: _____

Subscriber ID#:_____ Subscriber Name: _____

Referring Physician:_____Diagnosis:_____

Physician address: _____ Phone: _____

City_____ State_____ Fax: _____

Name, address, and phone number of who to call in case of emergency:

_____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Custom Fit Therapies or insurance company to release any information required to process my claims.

_____ _____

Signature Date

_____

Please Print