ADVANCE THERAPY
occupational, physical and speech therapy for children

REGISTRATION FORM

Which location? **Lino Lakes or White Bear Lake (circle one)**

Occupational, Physical, or Speech Language Therapy? (circle all that apply)

CLIENT INFORMATION:

CLIENT NAME:_____

DOB:_____ SS#:_____

STREET ADDRESS:_____

CITY:_____ STATE: _____ ZIP: _____

NAME OF PHYSICIAN SUPPORTING THIS RECOMMENDATION (OR PRIMARY CARE PHYSICIAN):

NAME:_____

CLINIC:_____

PARENTS/LEGAL GUARDIANS:

1. NAME:_____ MARITAL STATUS: **M S D W**

DOB:_____SS#:_____RELATION TO CLIENT:_____

STREET ADDRESS: (If different from above)_____

CITY:_____STATE:_____ZIP:_____

BEST PHONE:_____ OTHER PHONE:_____

BEST EMAIL:_____

2. NAME:_____

DOB:_____SS#:_____RELATION TO PATIENT:_____

ADDRESS (If different from above): _____

BEST PHONE:_____ OTHER PHONE:_____

INSURANCE:

- PRIMARY INSURANCE POLICY
  NAME:_____

GROUP #:_____ID #: _____

POLICY HOLDER:_____

EMPLOYER: _____

DOB: (If not listed on first page)_____

SS#:(If not listed on first page)_____

- SECONDARY INSURANCE
  NAME:_____

GROUP #: _____ ID#: _____

POLICY HOLDER:_____

EMPLOYER:_____

DOB: (If not listed on first page)_____

SS#:(If not listed on first page)_____

OTHER CONTACTS:

Please list other individuals who are involved in this patient's care, with which you authorize Advance Therapy to discuss the patient's treatment. (Spouse, step parent, grandparent, personal care attendant)

NAME:_____ EMERGENCY CONTACT:YES_____NO_____

RELATION TO PATIENT:_____

PHONE #1:_____ PHONE #2:_____

NAME:_____ EMERGENCY CONTACT:YES_____NO_____

RELATION TO PATIENT:_____

PHONE #1:_____ PHONE #2:_____

AUTHORIZATIONS:

I authorize Advance Therapy to provide information concerning the treatment plan of this patient listed above to insurance carriers, physicians, therapists and other personnel who are involved in the treatment and care of the patient.
I authorize payment of any medical benefits to Advance Therapy.
I certify that the above information is correct and that I am responsible for payment of services rendered.
I permit of copy of this to be used in place of the original.

SIGNATURE:_____DATE:_____
PARENT/LEGAL GUARDIAN OR SELF

Occasionally it is helpful to communicate general information about the services my child receives at Advance Therapy through email. As I read in Advance Therapy's Notice of Privacy Practices, it is important to keep some guidelines in place when communicating through email.

I, (name)_____, parent/guardian of

(child's name)_____, am providing the following email address and will let Advance Therapy know of any changes to this address.

EMAIL ADDRESS:_____

- I will keep this email account secure. _____ (initials)
- I will not send identifying information (i.e. client names, etc) to staff at Advance Therapy in my communications. *When emailing I will keep the subject line general and will not use full names.* _____ (initials)
- I will not attach reports (i.e. IEPs, etc) with identifying information when emailing to staff at Advance Therapy. *I know Advance Therapy is unable to email any therapy reports.* _____ (initials)

Signature:_____ Date:_____

How did you hear about Advance Therapy? Thank you!
Insurance Internet Search/Website Friend Physician School

Lino Lakes: 6776 Lake Drive #220 Lino Lakes, Mn 55014 Phone: 651-784-7007 Fax: 651-784-7992
White Bear Lake: 2555 Co Rd E East #102 White Bear Lake, Mn 55110 Phone: 651-683-2953 Fax: 651-705-0051
www.AdvanceTherapy.org