ADVANCE THERAPY
occupational, physical and speech therapy for children

REGISTRATION FORM 2024

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

Occupational, Physical, Speech Language, or Feeding 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:____ PHONE: ____

CLINIC:____ FAX: ____

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:______________________________________

***WHO IS THE BEST PERSON TO CONTACT RE: SCHEDULING?** ____

INSURANCE:

- PRIMARY INSURANCE COMPANY:______________________________

  NAME OF INSURANCE:____

GROUP #:________________________________ID #: ____

POLICY HOLDER:___________________________________

EMPLOYER if applicable: _______________________________________

DOB: (If not listed on first page)___________________________

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

- SECONDARY INSURANCE NAME:_______________________________

GROUP #: _______________________________ ID#: ____

POLICY HOLDER:___________________________________

EMPLOYER if applicable:____

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 client's/patient's care, with which you authorize Advance Therapy to discuss the child'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 client/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 am providing the following email address and will let Advance Therapy know of any changes to this address:

SECURE EMAIL ADDRESS:____

I, ____ agree to keep this email account secure and 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, not use full names and 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.*

Client/Parent/Guardian signature:____ Date: _________________

How did you hear about Advance Therapy? Thank you!

Insurance

Internet Search/Website

Friend/Current or Client

Physician

School

Other:

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