CHILDREN'S THERAPY
OF WOODINVILLE, P.L.L.C.

17311 135TH AVE NE, #C200 WOODINVILLE, WA 98072
(P) (425) 486-7710 (F) (425) 483-6059
childrenstherapyofwoodinville.com

PATIENT REGISTRATION FORM

PATIENT NAME (FIRST/INITIAL/LAST):	DATE OF BIRTH: / /	SEX: M_____ F_____

ADDRESS:	CITY:	STATE:	ZIP:

HOME: ( )	CELL: ( )	EMERGENCY: ( )	PARENT NAMES:

EMAIL:	BEST CONTACT METHOD: HOME____ CELL____ EMAIL____

PRIMARY INSURANCE COMPANY:	SUBSCRIBER NAME (FIRST/MIDDLE/LAST):

SUBSCRIBER EMPLOYER:	SUBSCRIBER ID NUMBER:	PLAN/GROUP NUMBER:	SUBSCRIBER BIRTHDATE: / /

RELATIONSHIP TO PATIENT:	HOME: ( )	WORK/CELL: ( )

SECONDARY INSURANCE COMPNAY OR FUNDING SOURCE:	SUBSCRIBER NAME (FIRST/MIDDLE/LAST):

SUBSCRIBER ID NUMBER:	PLAN/GROUP NUMBER:	SUBSCRIBER BIRTHDATE: / /

PRIMARY CARE DOCTOR:	ADDRESS:	HOME: ( )

PRIMARY REFERRAL CONCERN/DIAGNOSIS:	CODE (OFFICE USE ONLY):

I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES FOR SUCH TREATMENT. I AUTHORIZE CHILDREN'S THERAPY OF WOODINVILLE OR THE THERAPIST TO RELEASE ANY INFORMATION TO PROCESS MEDICAL CLAIMS. I ALSO AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE CLINIC. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES ASSOCIATED WITH MEDICAL SERVICES AND AGREE TO PAY THOSE CHARGES WHICH ARE MY RESPONSIBILITY. I ALSO UNDERSTAND THAT A $35 FEE (RCW62A.3-515&520) FOR RETURNED CHECKS WILL BE CHARGED. ANY UNPAID BALANCE OVER 60 DAYS IS SUBJECT TO A 1.5% MONTHLY FINANCE CHARGE (18% PER ANNUM). AN UNPAID PATIENT BALANCE OVER 90 DAYS MAY BE SENT TO COLLECTION.

SIGNATURE (PARENT OR GUARDIAN):	DATE: / /