REGISTRATION

DATE _____ APPT. DATE _____

PT _____ APPT. TIME _____

NAME _____ SEX ❑ M ❑ F
LAST FIRST MI

DX: _____

REFERRING PHYSICIAN _____ PRIMARY PHYSICIAN _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # _____ D.O.B. _____ SOC. SEC # _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____ PHONE _____
(Someone outside of home)

EMPLOYERS NAME _____ PHONE _____ LAST DAY WORKED _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

IS THIS A WORK RELATED INJURY? _____ ❑ YES ❑ NO DATE OF INJURY _____

SPOUSE NAME _____ EMPLOYER _____ PHONE _____

LAST DAY WORKED _____ ADDRESS _____

ADJUSTERS NAME _____ PHONE _____ CLAIM # _____

PRIMARY INS CO NAME _____ PHONE _____

IF PRIMARYINS. IS MEDICARE: HAVE YOU HAD PHYSICAL OR SPEECH THERAPY THIS YEAR? YES ❑ NO ❑

INSUREDS NAME _____ ID # _____ GROUP# _____

INSUREDS DOB: _____ INSUREDS SOC SEC # _____ SEX ❑ M ❑ F

SECONDARY INS CO NAME _____ PHONE _____

INSUREDS NAME _____ ID# _____ GROUP# _____

INSUREDS DOB: _____ INSUREDS SOC SEC # _____

RELATIONSHIP TO INSURED _____ SEX ❑ M ❑ F

I UNDERSTAND THAT ROHE THERAPY WILL FILE ALL CLAIMS TO MY INSURANCE AS A COURTESY; I THEREFORE GIVE MY PERMISSION TO RELEASE ALL NECESSARY MEDICAL RECORDS PERTAINING TO THESE CLAIMS FOR PROCESSING. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR THESE FEES WHETHER THE INSURANCE PAYS OR NOT. I GIVE ASSIGNMENT OF BENEFITS TO ROHE THERAPY FOR ALL TREATMENTS I RECEIVE WHILE UNDER THEIR CARE. I UNDERSTAND THIS MEANS ALL PAYMENTS FOR MY TREATMENTS WILL BE MAILED DIRECTLY TO ROHE THERAPY. IT IS ALSO MY UNDERSTANDING THAT AFTER MY INSURANCE (PAYS/DENIES), I AM RESPONSIBLE FOR ALL BALANCES. THE EXCEPTION TO THIS WOULD BE A CONTRACTUAL AGREEMENT BETWEEN ROHE THERAPY AND MY INSURANCE CARRIER. I HAVE ASKED ANY QUESTIONS CONCERNING MY FINANCIAL RESPONSIBILITY FOR THESE SESSIONS BEFORE I SIGNED THIS DOCUMENT.

_____ _____
MEDICAL RECORDS AUTHORIZATION ASSIGNMENT OF BENEFITS RELEASE

_____ _____
RESPONSIBLE PARTY & RELATIONSHIP TO PATIENT PATIENT