Patient Registration

Date:	First Name:	Last Name:	MI:	DOB:
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Would you like text or email appointment reminders: Text Email	Cell Phone Service Carrier:	
Email Address:		Social Security #:	Circle One: Male Female	
Emergency Contact Name:		Phone:	Relationship:	
Patient Employer:	Employer Address:	Employer Phone:		

If the patient is a minor or dependent, please complete this information:		
Father's Name:	DOB:	SSN:
Father's Employer:	Work Phone:	
Mother's Name:	DOB:	SSN:
Mother's Employer:	Work Phone:	

How did you hear about Gulf Coast Therapy?

◯ Referring Provider ◯ Current/Former Patient ◯ Website ◯ Internet/Google ◯ Friend/Family/Employee Name:_____

Responsible Party Information

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify Gulf Coast Therapy, Inc. of any changes in my status or the above information. I hereby authorize treatment(s) agreed upon with the therapist and my referring physician which are deemed medically necessary. Accounts not paid in full within thirty (30) days following completion of therapy and the billing process, may be turned over to collection.

I have been informed of my HIPAA rights and authorize the release of any information pertinent to my case to any insurance company, adjuster, referring physician, or attorney involved in this case. I also authorize Gulf Coast Therapy and its staff to call my home or cell phone and leave messages regarding appointments with my spouse and/or answering machine. Furthermore, I authorize the use of facsimile, email, internet, and electronic transmissions of my personal health information for the purpose of treatment, payment, and healthcare operations.

Responsible Party Signature: _____ Date:_____

Missing 3 appointments without notification may result in you being discharged from therapy and notification to your physician.

$25 CHARGE FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTIFICATION