GULF COAST THERAPY PATIENT REGISTRATION

DATE:	FIRST NAME:	LAST NAME:	MIDDLE INITIAL:	BIRTHDATE:

ADDRESS:	CITY:	STATE:	ZIP:	GENDER: (CIRCLE ONE: M F PREFER NOT TO ANSWER

PRIMARY PHONE NUMBER:	SECONDARY PHONE NUMBER:	EMAIL ADDRESS:
PATIENT EMPLOYER NAME:	EMPLOYER PHONE NUMBER:	EMPLOYER ADDRESS:

PATIENT SOCIAL SECURITY NUMBER:

EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE:	RELATIONSHIP:

IF PATIENT IS A MINOR OR DEPENDENT, PLEASE COMPLETE THIS INFORMATION

FATHER'S NAME:	BIRTHDATE:	SSN:

FATHER'S EMPLOYER:	EMPLOYER PHONE NUMBER:

MOTHER'S NAME:	BIRTHDATE:	SSN:

MOTHER'S EMPLOYER:	EMPLOYER PHONE NUMBER:

GULF COAST THERAPY MAY PROVIDE MY MEDICAL INFORMATION UPON REQUEST TO:

NAME:	PHONE NUMBER:	RELATIONSHIP:
NAME:	PHONE NUMBER:	RELATIONSHIP:

I DO NOT WISH TO AUTHORIZE ACCESS TO MY MEDICAL INFORMATION TO ANYONE ◯

MISSING 3 APPOINTMENTS WITHOUT PROPER NOTIFICATION MAY RESULT IN DISCHARGE FROM THERAPY AND NOTIFICATION TO YOUR PHYSICIAN. $50 CHARGE FOR MISSED APPOINTMENTS WITHOUT 24-HOUR NOTIFICATION

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 of any changes in my status or the above information. I hereby authorize treatment(s) agreed upon with the therapist and/or my referring physician which are deemed medically necessary. Accounts not paid in full within thirty (30) days following the 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.

Patient/Responsible Party Signature:____ Date:___________________________