Therapy Services Registration Form

Last Name_____First Name_____MI_____

Date of Birth_____ Gender_____ Race_____

Address: _____ City:_____ State: ___ Zip:_____

Contact Phone number: _____ Name of contact person: _____

Do You Have Medwaiver?____ Medicaid Number_____ WSC_____

Do You Have Medicare?_____ Medicare Number_____

Do You Have Medicaid?_____ Medicaid Number_____

Do You Have Insurance?_____ If yes, Insurance Provider_____Policy Number_____

Name of Insurance Policy Holder_____Relationship to You_____

Primary Care Physician_____

Address_____Phone_____

Specialists (if any)_____

_____

Diagnosis: _____

Concerns and goals for therapy: _____

EMERGENCY CONTACTS:

Name:_____ Name: _____

Address:_____ Address: _____

Phone:_____ Phone: _____

Relationship:_____ Relationship: _____

CONSENT TO SERVICES AND

AUTHORIZATION TO DISCLOSE AND EXCHANGE

PROTECETED HEALTH INFORMATION

Name_____ Date of Birth _____

I consent to receive therapy services from New Heights of Northeast Florida, Inc.

I authorize New Heights of Northeast Florida, Inc. to disclose and exchange my medical, developmental, educational, and other pertinent information (collectively referred to as “Protected Health Information”) with my primary care physician for the purpose of being provided therapy services.

I understand that I have the right to revoke this authorization at any time and, that if I do, I must do in writing to the New Heights of Northeast Florida CEO.

This authorization shall remain active until my discharge from New Heights of Northeast Florida early or until I revoke it in writing.

Signature_____ Date_____

Relationship to Individual Receiving Services_____

RELEASE OF INFORMATION FOR INSURANCE CLAIMS

Name_____ Date of Birth _____

I authorize the release of any medical, developmental, or educational information necessary to process insurance claims, including Medicaid and/or Medicare. I also authorize payment of benefits directly to New Heights of Northeast Florida, Inc.

Signature_____ Date_____

Relationship to Individual Receiving Services_____

ACKNOWLDEGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have been given a copy of New Heights' Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____