Therapedia #_____

Therapedia™, LLC
Exceptional therapy for children.

REGISTRATION FORM

Prescribing Physician_____

Patient/Child Information:

Child's Name_____ Child's Date of Birth____/_____/_____
Address_____
City_____ State_____ Zip_____ Sex _____male _____female
Primary Contact Phone #_____ email _____

Parent/Responsible Party

( )lives with child **Parent Name**_____ Address: ( )same as child _____ _____ Phone:_____ H W C DL#:_____ Date of Birth:_____	( )lives with child **Parent Name**_____ Address: ( )same as child _____ _____ Phone:_____ H W C DL#:_____ Date of Birth:_____

Emergency Contact *(other than parent)*

_____
_____
_____

Whom may we thank for the referral?

_____
_____
_____

AUTHORIZATION FOR TREATMENT

I authorize treatment of my child listed above and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received within 30 days of statement date.

_____ _____
Signature of Responsible Party Date

RELEASE AND AUTHORIZATION TO PAY THERAPEDIA, LLC

I understand that Therapedia, LLC may need to use and disclose information about my child's health or medical concerns for the purpose of arranging, conducting, or referring their treatment; for obtaining payment for services, and for the purpose of operating the practice. I consent to the use of my child's information to any insurance company, agency, adjuster, or attorney for the purpose of treatment, payment and health care operations.

_____ _____
Signature of Responsible Party Date