6 Edwin Street, Morgantown, WV 26501
304-292-0173 Phone | 304-292-0174 Fax
PlayWorkscdc.com

CLIENT INFORMATION/REGISTRATION FORM

Date: _____________

Last Name: ___________________________ First Name: ____________________ MI: ___

Client Social Security Number: _________________________

Street Address: ____

City, State Zip: ____

Client Date of Birth: _________________________________ Sex: F____ M____

Home Phone: ____________________ Cell: ___________________ Work: ___________________

E-mail Address: www:____

Which phone number is best to reach you: ________________________________

RESPONSIBLE PARTY

Mother's Name: _____________________________________ Mother's DOB: ________________

Mother's SSN#:______________________________________

Father's Name : _____________________________________ Father's DOB: _________________

Father's SSN#:______________________________________

Street Address (if different from above): ____

City, State, Zip: ____

Additional Caregiver Name (if applicable): _________________________ Telephone: ________________

INSURANCE

Referring Physician: __________________________ Diagnosis: ____________________________

Has the Client received any therapies within the past 6 months? _________

Primary Insurance Provider: _____________________________

€ PLEASE ATTACH A COPY OF **ALL** INSURANCE CARDS **FRONT AND BACK**

PLACE OF EMPLOYMENT: ____

€ PLEASE ATTACH A COPY OF THE PRESCRIPTION FROM REFERRING PHYSICIAN

Is Client enrolled in any WAIVER Programs? ______________

Name of Agency:____

Service Coordinator Name: ______________________________ Contact Number: _________________

EMERGENCY CONTACT NAME: ____

RELATIONSHIP TO CLIENT ______________________ PHONE _________________________

CONSENT FOR OCCUPATIONAL, PHYSICAL, AND/OR SPEECH THERAPY

I am entering PlayWorks Child and Adult Therapies voluntarily for the purpose of occupational, physical and/or speech therapy and do hereby consent to such treatment. I am responsible for paying for services provided to me, which may include collection fees. I authorize PlayWorks Child and Adult Therapies to release my medical records to any person or company who many need them for my continuing care, for payer review of medical services provided (utilization review) and/or for payment of my account.

____ __________________

Signature of insured/guardian Date

ASSIGNMENT AND RELEASE, GUARANTEE OF ACCOUNT

I hereby authorize and assign payment directly to PlayWorks Child and Adult Therapies for any medical benefits otherwise payable to me. I hereby authorize PlayWorks Child and Adult Therapies to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I accept responsibility for payment of the deductible, co-payment and non-covered services.

____ __________________

Signature of insured/guardian Date

MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE POLICIES OF PLAYWORKS CHILD AND ADULT THERAPIES AS DESCRIBED WITHIN THIS DOCUMENT.