Registration Form

River City Clinic, PA

Date____________________ **DX Code**________________________________

Therapist ______________________________

Patient Information

Patient Name (Print)____ **Date of Birth** ______________________________
Last Name First Name Initial

Street Address____ Home Phone ______________________________

City________________________________State________ZIP______________________ Work Phone ______________________________

Soc. Sec. #________________________Emergency Contact______________________________ Emerg Phone ______________________________

Gender____________________ Age__________________ Marital Status: □ Single □ Married □ Partnered □ Divorced □ Separated □ Widowed □ Other

Employer ________________________________ Occupation________________________________

Emergency Contact Name ________________________________ Phone ________________________________

Primary Insurance

Primary Insurance Company________________________________Phone ______________________________

Ins Claims Address________________________________City______________________State________Zip__________________

Policy/ID #________________________________Group/Plan #________________________________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name____Relationship ______________________________
Last name First Name Initial

Address________________________________City__________________________State______Zip____________**Date of Birth**______________

Soc. Sec#________________________________Employer________________________________

Secondary Insurance

Secondary Insurance Company________________________________Phone ______________________________

Ins Claims Address________________________________City______________________State________Zip__________________

Policy/ID #________________________________Group/Plan #________________________________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name____Relationship ______________________________
Last name First Name Initial

Address________________________________City__________________________State______Zip____________**Date of Birth**______________

Soc. Sec#________________________________Employer________________________________

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name ____Relationship ______________________________

Address____Phone ______________________________

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

________________________________ ______________________ ______________________
Responsible Party Signature Relationship To Patient Date