BOSTON A+BILITY CENTER

MAKING FUN AND FUNCTION GO HAND IN HAND

Outpatient Therapy Agreement and Registration Form

Date: ____________________

Patient's Name:	Nickname:	M/F	DOB:

Address:	City, State, ZIP:

Home Phone: ( ) _________________________________

1. Parent/Guardian Name: ___________________________ Cell: ( ) ______________________________
   Relationship: ____________________________________ Email: _________________________________

2. Parent/Guardian Name: ____________________________ Cell: ( ) _____________________________
   Relationship: ____________________________________ Email: _________________________________

Primary Care Physician: ___________________________________ Phone: ( ) ____________________________

PCP Address: ____ City, State, ZIP: __________________________________

Condition/Problem to be treated: ____

Referred by: _____PCP _____ Other:_____________________________________

Primary Insurance: ________________________	**Secondary Insurance:** _________________________
Policy Holder___________________ DOB______	Policy Holder ____________________ DOB_______
Relationship to Patient________________________	Relationship to Patient__________________________
ID/Subscriber #____________________________	ID/Subscriber #________________________________
Group #_______________ Employer___________	Group#________________ Employer______________
Phone: ( ) _____________________________	Phone: ( ) __________________________________

Consent: I give The Boston Ability Center consent to provide evaluation and treatment and to use or share my protected health information to obtain payment for my bills or to conduct its healthcare operations and business. I authorize payment to be made directly to The Boston Ability Center including Medicare, Medicaid or other benefits payable from any source, for all services rendered. I understand that I am ultimately responsible for payment of my account, and accept full responsibility for the cost of all services. I realize that I have the right to refuse any procedure after having the risks and benefits explained to me. The Boston Ability Center Summary Note of Privacy Practices was given to me. The Boston Ability Center is hereby released from all legal liabilities.

The Boston Ability Center may NOT release or share information with:

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Legal Guardian Signature Date

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Print Patient Name Relationship to Patient