THE BOSTON ABILITY CENTER
Outpatient Therapy Agreement and Registration Form

Date: _____

Patient's Name:

Male / Female DOB: Acct#

Address: City, State, ZIP:

Home Phone: ( ) _____ Work/Cell: ( ) _____ Email: _____

Parent/Guardian Name: _____ Relationship: _____

Address (if different from patient): _____

City/State/Zip: _____ Phone: ( ) _____

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:

_____

_____

Legal Guardian Signature Date

_____

Print Patient Name Relationship to Patient