

PATHWAYS THERAPY & WELLNESS CENTER

PATIENT REGISTRATION FORM

Patient Name: (Last): _____ (First) : _____ (Mid) Initial: _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell # _____

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed

Birth Date: _____ Age: _____ Sex: _____ Social Security #: _____

Employer: _____ Work # _____ Retired _____

Contact in Case of Emergency: _____ Relationship: _____

Emergency Contact Number: _____

SPOUSE INFORMATION

Spouse Name: _____ Date of Birth: _____

Social Security # _____ Employer: _____ Work # _____

PATIENT INSURANCE INFORMATION

Primary Insurance: _____

Address: _____ City: _____ State: _____

Zip code: _____ Phone: _____

Insured Name: _____ Social Security # _____

Date of Birth: _____ Relationship: _____

Policy #: _____ Group Number: _____

Secondary Insurance: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone _____

Insured Name: _____ Social Security # _____

Date of Birth: _____ Relationship: _____

Policy #: _____ Group Number: _____

Referring Physician: _____

I hereby consent to treatment by **PATHWAYS THERAPY & WELLNESS CENTER** I assign all medical benefits to which I may be entitled directly to **PATHWAYS THERAPY & WELLNESS CENTER** I understand that I am ultimately responsible for all charges, regardless of insurance coverage or lack thereof. Should a check be returned due to insufficient funds, a fee of \$25.00 will be charged to my account. Checks returned more than once will be assigned to a collection agency. In the event that my account is referred to a collection agency due to lack of payment on my part, I agree to pay all collection and legal fees that may be added to my account. I agree that there will be a 50% additional fee for all accounts turned over to collections. I hereby authorize the release of any medical information required by my insurance company.

Date: _____ Patient/Responsible Party Signature: _____

THANK YOU FOR CHOOSING THIS PRACTICE FOR YOUR MEDICAL NEEDS!
2298 WEST HORIZON RIDGE SUITE 201
HENDERSON, NV 89052-2698