'IKE LOA
Therapeutic Services

Registration Form

Please print clearly. Mark N/A for "not applicable" Date:_____

Personal Information	
Name:	
Social Security Number:	Date of Birth:
Sex (check applicable): M___ F___ Other:_____	
Marriage Status (check one): Single_____ Married_____ Widowed_____ Separated_____ Divorced_____	
Address:	
Cell Phone:	Home Phone:
E-mail Address:	
Occupation (or Grade in school):	
Employer (or School):	Work Phone:

Account Information

Person responsible for payment:_____
Relationship to patient: _____

Primary Insurance
Insurance Plan: _____ID#_____
Name of Insured: _____ Insured's Date of Birth: _____

Secondary Insurance
Insurance Plan:_____ID#_____
Name of Insured: _____ Insured's Date of Birth: _____

Complete the following section ONLY if client is a minor:

Parent/Legal Guardian's Name: _____Relationship: _____
Cell Phone: _____ Home Phone: _____Work Phone: _____
Mailing Address: _____
**Minor client's parent/legal guardian must sign this registration form.*

If the legal guardian is CPS/DHS or another state, federal, or private agency,please complete the below information:
Name of assigned worker/agency:_____Phone: _____

I understand and agree that regardless of my insurance status, I am responsible for any balance on my account for services rendered. I have completed the above information to the best of my knowledge and will notify you of any changes within 30 days of any changes. I hereby authorize the release of any medical information necessary to process my insurance claims and payments of insurance benefits to Ike Loa Therapeutic Services, Inc. for services rendered. I understand that I will be charged 1% per month of any outstanding balance on my account, as well as any and all legal fees if a collection process becomes necessary on this account. I agree to give 24 hours cancellation notice, and I understand that if I miss two consecutive appointments, I will be charged a $50.00 no show fee.
*****I acknowledge that I understand, and agree to, all of the statements above**:***

Signature: _____ Date: _____
(patient, parent or legal guardian)
Relationship to patient if signed by patient representative: _____
Print Name: _____