CENTER FOR THERAPEUTIC INTERVENTION PATIENT REGISTRATION

Patient Name	Birthdate		
Home Phone	Referring Physician/Pedia	atrician	
Email Address to Receive Statements			
	PARENT INFORM	MATION	
Parent Name	DOB	Home Phone	
Address (if different from patient)			
		Home Phone	
	Phone Number		
			2000
Primary Insurance			
Insurance Company	Provider Phone Number		
Policy/ID Number	Group Number		
		ployer	
Secondary Insurance	*		-
Insurance Company	Provi	der Phone Number	
	Group Number		
		mployer	
		mproyet	
I understand that I will be responsible for payment of all so	ervices rendered. I hereby authorize C	CENTER FOR THERAPEUTIC INTERVENTION to furnish the insurance company w	with
any requested information. I authorize payment of medic	al benefit to CENTER FOR THERAPEUT	IC INTERVENTION for any services rendered.	

Signature of Parent/Guardian_______Date_____

Printed Name of Parent/Guardian