FOCUS THERAPY SERVICES, INC.

Mailing Address	Main Office	Bayboro Office	Morehead City Office
PO Box 12192	3310-A Neuse Blvd.	14180 NC Hwy 55	5242 US Hwy 70 W
New Bern, NC 28561	New Bern, NC 28560	Bayboro, NC 28515	Morehead City, NC 28557
Fax# 252-672-8677	T# (252)672-8676	T# (252)745-5500	T# (252)222-3343

Registration

Pediatric

Patient:	Sex: ☐ M ☐ F		DoB ___/___/_____
Patient lives with: ☐ Mother ☐ Father ☐ Guardian	Patient SS#:		
Is Patient adopted?: ☐ Yes ☐ No	If adopted, please specify date of adoption: ___/___/_____		
Mother/Guardian:			DoB ___/___/______
Address:	Mother SS#:		
City, State, Zip:	Home Phone:		
Employer:	Work Phone:		
Father/Guardian:			DoB ___/___/______
Address:	Father SS#:		
City, State, Zip:	Home Phone:		
Employer:	Work Phone:		
Sibling:	Sex: ☐ M ☐ F		DoB ___/___/_____
Sibling:	Sex: ☐ M ☐ F		DoB ___/___/_____
Sibling:	Sex: ☐ M ☐ F		DoB ___/___/_____
Emergency Contact Name:	Relation:	Phone:	
Referring Physician:			
Primary Insurance:	ID#/Policy #	Group #	
Name of Insured:	Employer:		
Secondary Insurance:	ID#/Policy #	Group #	
Name of Insured:	Employer:		

Authorization of Treatment and Assignment of Benefit

I authorize **Focus Therapy Services, Inc.** to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to **Focus Therapy Services, Inc.** for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following ____ .
I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent'/Guardian's signature ______________________ Relationship ____________________ Date __________

Witness' signature ____ Date __________

☐ I prefer to do my own insurance filing, Signed ____________________________________ Date __________

HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.