Choice Therapy – Hibbing
1101 East 37th Street, Suite 20
Mesabi Mall
Hibbing, MN 55746

Choice Therapy

Phone: 218.440.1548
Fax: 218.440.1551
ChoiceTherapyHibbing.com

Date:

Last Name:_____ First Name:_____
Addresss:_____ Apt or PO Box:_____
City:_____ State:_____
Zip:_____ **Email:**_____
SSN:_____ DOB:_____

Phone Numbers
Home Phone:_____
Work Phone:_____
Cell Phone:_____

Emergency Contact
Last Name:_____ First Name:_____
Phone:_____
Relationship:_____

Employer (Required on all Workers Compensation cases)
Name:_____
Address:_____ Suite or Office Number:_____
City:_____ State:_____
Zip:_____

Problem
Problem Description:_____
Referred by:_____
Referral Information:_____
Date of Onset:_____

____**PRIVATE PAY OPTION.** (If you have Medicare, MA, or a state health plan, you are not eligible)

*Consider Private Pay if:
-You have a high deductible medical plan & you have NOT met your deductible
-you do not have insurance

*Price:
-$100 per initial visit
-$75 per visit for follow-ups
***Payment by cash, check, or credit card is required same day of service**

OR

____**Bill my insurance company.** Once charges have been submitted to insurance, private pay option is not available.

(INSURANCE INFO NOT APPLICABLE WITH PRIVATE PAY OPTION)

Primary Insurance

Insurance:_____ ID Number:_____
Group Number:_____ Claim Number:_____
Deductible:_____ Max Annual Benefit:_____
Copay:_____ Coinsurance:_____
(Copays and Coinsurance are due at the date of service)
Subscriber Information
Subscriber Name:_____
Subscriber Date of Birth:_____
Subscriber Relation to Patient:_____

Secondary Insurance

Insurance:_____ ID Number:_____
Group Number:_____ Claim Number:_____
Deductible:_____ Max Annual Benefit:_____
Copay:_____ Coinsurance:_____
(Copays and Coinsurance are due at the date of service)
Subscriber Information
Subscriber Name:_____
Subscriber Date of Birth:_____
Subscriber Relation to Patient:_____

Motor Vehicle Accident Injuries
If you are receiving care for injuries from a motor vehicle accident, what state did the accident occur in?
___Date:___/___/_____

Patient or Guardian Agreement: (Please Check)

___ I authorize release of information requested by my insurance plan for payment or referring physician.
___ I understand that I am responsible for any balance due.
___ I agree to comply with the terms and conditions as outlined in the Patient Registration form.
___ I consent to Choice Therapy to render appropriate treatment as prescribed by my physician.

Signature of Patient or Guardian: _____ Date ___/___/_____