Bolanos | Associates
Comprehensive Therapy Solutions

Patient Registration

Patient Information

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____ State:_____ Zip:_____

Claim No:_____ Date of Injury / Illness:_____ Surgery Date:_____

SSN No:_____ Age:_____ Race:_____ Gender:_____ D.O.B:_____

Telephone:_____ Mobile:_____Email:_____

Known Allergies:_____

Emergency Contact:_____ Telephone:_____ Relationship:_____

Work Injury/ Car Accident :_____

Attorney: _____ Telephone:_____ Fax:_____

Insurance Information

Insurance Company (1):_____ Policy Number:_____

Case Manager:_____ Telephone:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____

Insurance Company (2):_____ Policy Number:_____

Case Manager:_____ Telephone:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____

Physician Information

Physician Name:_____ Physician Telephone:_____

Address:_____ City:_____ State:_____ Zip:_____

Patient's Authorization to Release Medical Information and Claim Payment Authorization

I _____ hereby authorize Bolanos Associates, LLC to release any information regarding services rendered by them and allow copies of my signature to be utilized to file insurance.

Patient's Signature (Parent or Guardian if Minor) _____ Date _____

I _____ hereby authorize and direct payment check(s) for benefits due to me for the services rendered by Bolanos Associates, LLC. to be made directly to them, regardless of insurance benefits, if any. I unconditionally understand that I am financially responsible for the fees for services rendered.

Patient's Signature (Parent or Guardian if Minor) _____ Date _____

I _____hereby understand that in the event I cannot attend my scheduled appointment for services to be rendered, then it is my sole responsibility to contact Bolanos Associates, LLC, no later than twenty-four (24 hours) of my appointment date and time and either cancel or reschedule accordingly, otherwise a Forty ($40) No Show Fee will be assessed to me. I further understand that failure to do so on three consecutive occasions may cause Bolanos Associates, LLC. to discontinue any further treatment and discharge me.

Patient's Signature (Parent or Guardian if Minor) _____ Date _____