



278 Monmouth St., Suite 1  
Jersey City, NJ 07302  
(201) 324-1700  
Fax: (201) 324-1788

**REGISTRATION FORM/ CLIENT INFORMATION**

(Please Print)

Today's Date: \_\_\_\_\_

Child's Last Name: \_\_\_\_\_ First: \_\_\_\_\_

Middle: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_

Sex: F  M

Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

\*\*\*\*\*

Referred to clinic by: (Please check one box)

Dr.  Insurance Plan  Hospital  Family  Friend

Close to home/work  Yellow Pages  Other: \_\_\_\_\_

Person responsible for bill: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: (if different): \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**INSURANCE INFORMATION:**

Please indicate Primary Insurance Name:

\_\_\_\_\_

Subscriber's Name:

\_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Birth Date: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Co-Payments:\$ \_\_\_\_\_

Insurance Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Name of Secondary Insurance (if applicable): Yes  No

\_\_\_\_\_

Subscriber's Name:

\_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Child's relationship to Subscriber: Self  Spouse  Child

Other \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Phone#: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_      Cell Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**INSURANCE DECLARATION:**

Please hand your insurance card over to the Administrator so she can make a copy.

\*\*\*\*\*Please be advised that Sensory Kids LLC is not an In-Network Provider, but rather an Out-of-Network Provider. Therefore, in order for us to file for insurance coverage for any medical claims, the deductible specifically for Out-of-Network Benefits must be met. Please also note that as a courtesy, if the deductible has not been met before or at the time of our services, we can arrange a payment plan for your convenience. As a reminder please be aware that any balances not covered by your insurance will be your responsibility.

**I understand and I am financially responsible for paying my total bill within 90 days of treatment, (whether my insurance company has made payment or not), and agree that if any bills is not paid within 90 days from the date of treatment, my bill may be sent to a collection agency where my credit will be affected. Furthermore, I am responsible for any legal, interest, or collection costs associated with my account.**

Thanks for your cooperation in this matter. The above information is true to the best of my knowledge. I authorized my insurance benefits to be paid directly to the private practice of Sensory Kids LLC. I authorize Sensory Kids or my insurance company to release any information required to process my claims.

Your appointment time is specially reserved for you. If you need to cancel for any reason, you must allow us at least 24 hours advance notice. Failure to do so will result in a 50% service charge to your appointment. In trying to do our best to serve you we recommend that you always reschedule and confirm your appointments before leaving the office.

Client Guardian Signature: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_