

# The Right Step

Therapy Services LLC  
517.914.0800

## Registration Information

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Client or Parent Drivers License #: \_\_\_\_\_  
Telephone: (day) \_\_\_\_\_ (evening): \_\_\_\_\_ Beeper: \_\_\_\_\_  
Address: \_\_\_\_\_ e-mail: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

***If Applicable: Parent or Guardian of client please complete the following***

Parent/ Guardian: \_\_\_\_\_  
Address and Phone same as above? YES NO \_\_\_\_\_

***If child is not living with both parents, please complete the following:***

Custody: joint single Custodial parent: \_\_\_\_\_  
Address of noncustodial parent: \_\_\_\_\_

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**YES NO** I Authorize The Right Step Therapy Services LLC to arrange all necessary medical attention in case of emergency.

**\*\*\*\*\*EMERGENCY CONTACT:** \_\_\_\_\_ **\*\*\*\*\***  
(name and telephone #)

Referring Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

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## Insurance Information

Primary Insurance:  
Insurance Company: \_\_\_\_\_ Group/ Plan Number: \_\_\_\_\_  
Insurance Company Street/ P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Does this plan cover all family members? YES NO

Name of Policy holder: \_\_\_\_\_ Relationship to client: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Secondary Insurance? YES NO

Insurance Company: \_\_\_\_\_ Group/ Plan Number: \_\_\_\_\_  
Insurance Company Street/ P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Does this plan cover all family members? YES NO

Name of Policy holder: \_\_\_\_\_ Relationship to client: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Do you have a third insurance company? YES NO

*I authorize payment of medical benefits to myself or the named provider for professional services rendered. I authorize the release of any information necessary to process my medical claim. I verify the above information is accurate and I understand it is my responsibility to immediately update, in writing, any changes in my registration information.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_