

ADULT

Louise Levy, M.S. CCC-A
863 Park Avenue, Suite 1E | New York, NY 10075
Tel: 212.472.1350 | Fax: 212.472.1336

Registration Form (Please Print)

Today's Date ____/____/____

Patient Information

Name _____
Last First Middle

Street Address _____ Apt # _____

City _____ State _____ Zip _____ Sex M / F

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Marital Status _____

DOB ____/____/____ Age ____ SS ____ - ____ - ____ Email _____

**New Government regulations require medical offices to ask the following –*

Preferred Language _____ Race _____ Ethnicity _____

In Case of Emergency, Contact _____ Phone: _____ Relationship: _____

Primary Insurance

Insurance _____ Policy Number _____

Referred By _____

Occupation _____

Employer Name _____ Phone _____

Employer Address _____

Send Report To:

Doctor: _____ Phone: _____

Address: _____

Therapist: _____ Phone: _____

Address: _____

All medical records at the medical office of Louise Levy, M.S. CCC-A are strictly confidential and comply with all of the laws set forth in compliance with HIPAA.

I, the undersigned, authorize the release of medical information to any and all parties as determined by practitioner if needed, and as necessary to process insurance claims and, where applicable, comply with federal, state and local requirements. I also authorize payment of benefits to Louise Levy, M.S., CCC-A

I understand and agree that I am responsible for the balance of my account for any professional services rendered, including any unmet deductibles, co-payments and non-covered services, and I authorize ALL insurance payments to Louise Levy, M.S. CCC-A for services rendered.

Patient or Responsible Party (if minor) Signature _____

Name of Signer _____ Relation to Patient _____ Date ____/____/____