KNOXVILLE MUSIC THERAPY

REGISTRATION FORM

(Please Print)

Today's date:					Account No.

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Age:	Sex: ❑ M ❑ F	Diagnosis:

Address:	Social Security no.:	Home phone no.: ( )

City:	State:	ZIP Code:	Occupation:	Cell Phone: ( )

Employer:	Employer Address:	Employer phone no.: ( )

Email Address:

Referred to KMT by (please check all that apply): ❑ Dr. ______________________ Phone: ______________

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Website ❑ Hospital / Clinic ❑ Other ___________________

Reason for seeking Music Therapy:

PARENT / GUARDIAN INFORMATION

Parent / Guardian:	Mother / Father Other:	Address (if different):	Home / Cell phone no.: ( )
Primary Caregiver?	❑ Yes ❑ No	Email:	Best Contact: ❑ Home ❑ Cell ❑ Work
Occupation:		Employer:	Work phone no.: ( )

Parent / Guardian:	Mother / Father Other:	Address (if different):	Home / Cell phone no.: ( )
Primary Caregiver?	❑ Yes ❑ No	Email:	Best Contact: ❑ Home ❑ Cell ❑ Work
Occupation:		Employer:	Work phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I agree to update my contact information in a timely manner. I also authorize Knoxville Music Therapy to release information provided here as required by law.

Patient / Guardian signature *Date*

Co:11/16 Ud:4/17ads

DOB / acct No__________________________

PATIENT HISTORY

Last:	First:	Middle:	Date:

Primary Care Physician:	Phone:	Address:

Please list any medications you (or your child if filling out for dependent) are currently taking:

Medication:	Dose:	Frequency:	Reason / purpose:

CURRENT THERAPIES

Please list any other therapists or health care professionals you (or your child) are currently receiving services from, contact information, and frequency of visits (i.e. Occupational Therapy, Speech, Physical Therapy, etc.)**

Name:		Name:
Profession:		Profession:
Phone: ( )		Phone: ( )
Email:		Email:
Frequency per week/ month:		Frequency per week/ month:
Reason:		Reason:
Name:		Name:
Profession:		Profession:
Phone: ( )		Phone: ( )
Email:		Email:
Frequency per week/ month:		Frequency per week/ month:
Reason:		Reason:

***(attach additional sheet if needed)*

PAYMENT INFORMATION

Person responsible for Payment of Services: ❑ Self ❑ Spouse ❑ Parent / Guardian ❑ Other :

Preferred form of Payment: ❑ Cash ❑ Check ❑ Credit** ❑ Other :

***Please note: Credit card payments are accepted in-person, or via PayPal payment to adseaton@knoxvillemusictherapy.com*

The above information is true to the best of my knowledge. I understand that I am financially responsible for all account balances. I authorize any insurance benefits, grants, or claims pertaining to music therapy services to be paid directly to Alana Dellatan Seaton, MMT, MT-BC dba “Knoxville Music Therapy”. I also authorize Knoxville Music Therapy to release information required to process any claims, grant funds, or other financial award to entities responsible for disbursement of funds pertaining to music therapy services. I understand that the information given above is confidential, and that the release of this information to parties beyond those noted above will be granted only by my written consent.

_______________________________________ _______________________

Patient / Guardian signature *Date*