KNOXVILLE MUSIC THERAPY, LLC

REGISTRATION FORM

(Please Print)

Today's date:	Account No.

PATIENT INFORMATION

Last name: First: Middle:	Preferred Pronouns:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Age:	Gender: ❑M ❑F ❑Other	Diagnosis:

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

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

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

Employer Address:

Current School:	School Address:	Years attended:	School phone no.: ( )

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 / SPOUSE INFORMATION

Primary Parent/ Contact / or Spouse:	Mother / Father Other:	Address (if different):	Home / Cell phone no.: ( )

Legal Guardian? ❑ Yes ❑ No	Email:	Best Contact: ❑ Home ❑ Cell ❑ Work

Occupation:	Employer:	Work phone no.: ( )

Secondary Parent / Contact:	Mother / Father Other:	Address (if different):	Home / Cell phone no.: ( )

Legal Guardian? ❑ 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, LLC to release information provided here as required by law.

Patient / Guardian signature *Date*

Co:11/16 Ud:4/17ads, Ud 2//20ads, ud 4/23bap

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** ❑ PayPal ❑ Other (Please specify):

Please note: Credit card payments are accepted in-person, with Stripe via client Practice in Tune portal and invoices, or online at* ***www.paypal.me/knoxvilleMTBC

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 Knoxville Music Therapy, LLC. I also authorize Knoxville Music Therapy, LLC 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*