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Center for Autism & Developmental Disabilities
At Touro University Nevada

(T.U.N. CADD)

# Registration Form

## Patient Information

Date: _____

Name: _____ Home Phone: (  )

Address: _____ Cell Phone: (  )

City: _____ State: _____ Zip: _____

Sex: ❑M ❑F Age: _____ Birthdate: _____ SSN: _____

Patient's School: _____

Mother's Name: _____ Father's Name: _____

Parent(s) Marital Status: ☐ Married ☐ Divorced ☐ Separated Custodial Parent: _____

Who Shall we thank for referring you? _____

In case of emergency who should be notified? _____ Phone: _____

## Primary Insurance

Person Responsible for Account: _____

*Last Name* *First Name* *Middle Initial*

Relationship to Patient: _____ Birthdate: _____ SSN: _____

Address (if different from patient): _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____ Subscriber #: _____ Group #: _____

Names of other dependents covered under this plan: _____

## Additional Insurance

Is the Patient covered by additional Insurance? ❑Yes ❑No Subscriber Name: _____

Relation to Patient: _____ Birthdate: _____ SSN: _____

Address (if different from patient): _____ Phone: _____

City: _____ State: _____ Zip: _____

Subscriber Employed by: _____ Business Ph: _____

Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____ Subscriber #: _____ Group #: _____

Names of other dependents covered under this plan: _____

**Assignment and Release:** I hereby assign all medical benefits to which I am entitled to T.U.N. CADD in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to, the collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of T.U.N. CADD as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

_____ _____

**Please print name of Patient, Parent, Guardian or Personal Representative** **Relationship to Patient**

_____ _____

**Signature of Patient, Parent, Guardian or Personal Representative** **Date**