J2 Therapy and Wellness
46161 Westlake Drive , Suite 330
Sterling, VA 20165-5871

Phone: (703) 444-9562
Fax: (703) 430-2124

Date of Birth:

Last Name: First Name:

Address: Apt or PO Box:

City: State: VA

Zip:

Phone Numbers:

Home Phone: ( ) _____-_____

Work Phone: ( ) _____-_____

Cell Phone: ( ) _____-_____

Appointment Reminders:

Complete the section and sign below if you choose to give permission for J2 Therapy and Wellness to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

☐ J2 Therapy and Wellness may send email messages to confirm my upcoming appointments to _____

☐ J2 Therapy and Wellness may send cell phone text messages to confirm my upcoming appointments to _____.

I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email/text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

☐ ALLTel	☐ Nextel
☐ AT&T	☐ Qwest
☐ Boost Mobile	☐ Sprint PCS
☐ Cingular	☐ T Mobile
☐ Cricket Wireless	☐ US Cellular
☐ Metrocall	☐ Verizon
☐ MetroPCS	☐ Virgin Mobile

EMAIL ADDRESS:_____

_____

Signature of Patient or Guardian

Emergency Contact

Last Name: First Name:

Phone: ( ) _____-_____
Relationship:

Employer

Name:
Address:
Suite of Office Number:
City:
State:
Zip:

Problem

Problem Description:
Referred by:
Date of Onset: ___/___/_____

Primary Insurance

Insurance:
ID Number:
Group Number:
Claim Number:
Deductible:
Max Annual Benefit:
Copay:
Coinsurance:

Subscriber Information

Subscriber Name:
Subscriber Date of Birth: ____/____/_____
Subscriber Relation to Patient:
☐Self ☐Spouse ☐Parent ☐Other

Secondary Insurance

Insurance:
ID Number:
Group Number:
Claim Number:
Deductible:
Max Annual Benefit:
Copay:
Coinsurance:

Subscriber Information

Subscriber Name:
Subscriber Date of Birth: ____/____/_____
Subscriber Relation to Patient:
☐Self ☐Spouse ☐Parent ☐Other

Tertiary Insurance

Insurance:
ID Number:
Group Number:
Claim Number:
Deductible:
Max Annual Benefit:
Copay:
Coinsurance:

Subscriber Information

Subscriber Name:
Subscriber Date of Birth: ____/____/_____
Subscriber Relation to Patient:
☐Self ☐Spouse ☐Parent ☐Other

Motor Vehicle Accident Injuries

If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in?

_____

PATIENT or Guardian Agreement: ALL PATIENTS MUST SIGN

I authorize release of information requested by my insurance plan for payment and authorize J2 Therapy and Wellness to apply for benefits on my behalf for services rendered by them, and request payment from my insurance carrier be made directly to J2 Therapy and Wellness.
I understand that I am responsible for any balance due to include no-show, late and/or cancellation fees (two business day notice requirement).
I agree to comply with the terms and conditions as outlined in the Patient Registration form.

Signature of Patient or Guardian: _____ Date ____/____/_____

Notice of Privacy Practices:

I hereby acknowledge that I have have been offered a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature of Patient or Guardian: _____ Date ____/____/_____