

ADMISSION APPLICATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

E-MAIL _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

INSURANCE PROVIDER _____ PHONE _____

ID # _____ GROUP # _____

NAME OF PRIMARY INSURED _____

EMERGENCY CONTACT _____

RELATIONSHIP _____

HOME PHONE _____ CELL PHONE _____

PHYSICIAN _____ PHONE _____

THERAPIST _____ PHONE _____

HOW DID YOU FIND US? _____

I am applying for admission to Oliver-Pyatt Centers. I understand that admission is subject to submission and review of my Recovery Statement, Admission Questionnaire, and Medical Assessment. All will be reviewed by the members of the clinical team of Oliver-Pyatt Centers.

A \$2,500 non-refundable deposit is required to secure a place for myself on the waiting list. The deposit will be applied to the cost of care. If for any reason it is determined that my medical or psychological needs exempt me from being accepted for admission to Oliver-Pyatt Centers, the deposit will be promptly refunded to me.

*Please fax this form to 305-667-4408, and send your deposit check, payable to Oliver-Pyatt Centers, to:
Oliver-Pyatt Centers | Attn: Admissions | 6150 SW 76th Street | South Miami, FL 33143*

CLIENT SIGNATURE _____ DATE _____

NAME OF FINANCIAL GUARANTOR _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

GUARANTOR SIGNATURE _____ DATE _____