WACONIA CHIROPRACTIC

PATIENT REGISTRATION FORM

(PLEASE PRINT)

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name First Name Middle Initial

Responsible Party (if patient is a minor) _____

Home Phone _____ Cell Phone _____ Email _____

Street Address _____

City _____ State _____ Zip _____

Gender ☐ Male ☐ Female Age _____ Date of Birth ____/____/____

☐ Employed ☐ Full Time Student ☐ Part Time Student Patient's School Name _____

Patient Employed By _____ Occupation _____

Business Phone _____ How did you learn of our practice? _____

Emergency Contact Name and Relationship _____ Phone _____

INSURANCE INFORMATION

Will we be filing to insurance for you?

☐ Yes (complete info below) ☐ No, I agree to pay on the date of service _____
Signature

Primary Insurance _____ Subscriber # _____ Group # _____

Secondary Insurance _____ Subscriber # _____ Group # _____

ACCIDENT OR INJURY

Is your condition related to an injury from an accident? ☐ Yes (complete info below) ☐ No

Injured in an auto accident? ☐ Yes (complete info below) ☐ No

If yes, Insurance Name _____ Claim Number _____

Claims Filing Address _____

City _____ State _____ Zip _____

Injured at work? ☐ Yes (complete info below) ☐ No

If yes, Insurance Name _____ Claim Number _____

Claims Filing Address _____

City _____ State _____ Zip _____

(OVER)

PATIENT REGISTRATION FORM

(PAGE 2)

Patient Name _____ _____

TREATING PHYSICIANS

Are you currently under the care of a physician? ☐ Yes (complete info below) ☐ No

Treating Provider _____ City/State _____

(General Practitioner, Specialist or Other)

Treatment received? _____

INSURANCE BENEFIT AUTHORIZATION

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I, the undersigned, assign directly to Dr. Berry all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all my insurance submission whether manual or electronic.

_____ _____

Signature of Insured/Guardian **Date**

MEDICARE AUTHORIZATION (for Medicare Beneficiaries Only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Berry for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Insured/Guardian **Date**

NOTICE OF PRIVACY PRACTICES (HIPPA)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Signature of Insured/Guardian **Date**