



Patient Registration Form

Patient Information

Last Name: _____ First Name: _____ MI _____
Mailing Address: _____ City/State/Zip: _____
Physical Address: _____ City/State/Zip: _____
Primary Phone: _____ Type: Home Cell Work **Message ok?** Y or N
Alternate Phone: _____ Type: Home Cell Work **Message ok?** Y or N
Email: _____ Ok for **Doctor Contact** Y or N **Newsletter** Y or N
Social Security Number: _____ Date of Birth: _____ Male Female
Marital Status: S M D W O
Employer: _____ Occupation: _____

Responsible Party Information (Parent information if patient is a Minor)

Name: _____
Address: _____ City/State/Zip: _____
Primary Phone: _____ Alternate Phone: _____

Insurance Information

*Primary Insurance Company Name: _____
*Patients Relationship to Insurance Subscriber: Self Spouse Child Other
*Name of Subscriber: _____ *Date of Birth: _____
*Social Security Number: _____ Male Female
*Insurance ID#: _____ Group#: _____

*Secondary Insurance Company Name: _____
*Patients Relationship to Insurance Subscriber: Self Spouse Child Other
*Name of Insured: _____ *Date of Birth: _____
*Social Security Number: _____ Male Female
*Insurance ID#: _____ Group#: _____

Emergency Contact Information

Name: _____ Relationship: _____
Primary Phone: _____ Alternate Phone: _____

I certify that the above is true and correct to the best of my knowledge. 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 insurance submissions.

Patient/Responsible Party Signature: _____
Responsible Party's Relationship to Patient: _____
Today's Date: _____

*** This information is valid for duration of treatment, unless otherwise revoked in writing by patient.**



Health Information Practices Notice

Law requires the privacy of your health information to be maintained as confidential and not shared with any outside parties. As such, Ray Wilbur, DC will not disclose any of your health information to any outside organizations, with the exception and purpose of:

- Professional referral to another healthcare provider, hospital, or clinic for diagnosis, assessment, or treatment.
- Collection of payment for services rendered (i.e. your insurance company).
- Office administration including phone calls. If you are not available to receive the call, a message will be left on your answering machine.

This is a summary of our disclosure practices. Full disclosure packet is available upon request at the front desk.

I understand that if I wish to place any restrictions to this Health Information Policy, I must make my request in writing. My request can be placed at any time. All requests will be reviewed and responded to within 30 days. I will address concerns to: Ray Wilbur, DC, 175 Concourse Boulevard, Santa Rosa, CA, 95403

Responsible Party Signature

Date

Electronic Chart Storage and Information Sharing

I understand that Dr Wilbur and all practitioners at 175 Concourse Blvd. (IMC) use the same electronic medical record. All patient records are accessible for review by my treating provider(s), with the exception of notes for psychological visits. I understand that I may request specific psycho-social information to be kept in the confidential section of my record. This information can only be released with my specific authorization to do so and is not available to other practitioners.

I also understand that Dr. Wilbur may discuss my diagnosis and treatment options with other practitioners at IMC, so that I can benefit from an integrative approach to my healthcare.

Responsible Party Signature

Date

Patients Paying Privately (no insurance)

I understand it is the policy of Dr. Ray Wilbur to require payment in full at the time of service and any check or credit card payment that is returned will incur an additional \$25 charge. Consecutive missed appointments without 24 hours notice may be subject to \$30 missed appointment fee.

Responsible Party Signature

Date



Medicare Authorization

I request that payment of authorized Medicare benefits be made to Dr. Ray Wilbur for services rendered. I understand my signature allows payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9a of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes information to be released to the insurer or agency shown. Dr. Wilbur is a participating Medicare provider and agrees to accept the charge determination of the Medicare carrier as the full charge. I further understand that I am responsible for the deductible, coinsurance, and non-covered services (such as initial chiropractic exam). Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Returned check or credit card payments will incur a \$25 additional charge. Consecutive missed appointments without 24 hours notice may be subject to \$30 missed appointment fee.

Responsible Party Signature

Date

In-Network Billing Patient Release (contracted insurances)

Dr. Ray (Frank) Wilbur is a contracted provider with my insurance carrier; however, I agree to be financially responsible for all charges should my insurance policy exclude chiropractic benefits. I authorize the office of Dr. Ray (Frank) Wilbur to submit my medical and billing information to my insurance carrier in order to collect payment for services rendered. I understand it is my responsibility to know my policy and verify my coverage benefits directly with my insurance carrier. Co-payment is due at the time of service. In some cases, an initial billing may be submitted to determine exact co-payment as according to my benefit plan.

Returned check or credit card payments will incur a \$25 additional charge. Consecutive missed appointments without 24 hours notice may be subject to \$30 missed appointment fee.

Responsible Party Signature

Date

Courtesy Billing Patient Release (non contracted insurances)

I understand it is the policy of Dr. Ray Wilbur to require payment for services rendered at the time of visit. I agree to be financially responsible for all charges and pay for all services, whether or not they are covered by my insurance. I authorize submittal of my medical and billing information to my insurance carrier in order that I might be reimbursed directly for any services that are covered by my policy. I understand that Dr. Wilbur submits my bill as a courtesy to me and does not guarantee any insurance benefit. It is my responsibility to verify my coverage directly with my insurance carrier. I understand that I will incur a \$25.00 additional charge for any returned check or credit card payments. Consecutive missed appointments without 24 hours notice may be subject to \$30 missed appointment fee.

Responsible Party Signature

Date

ALL PATIENTS, PLEASE COMPLETE CHIROPRACTIC INTAKE FORM AS WELL.

* This information is valid for duration of treatment, unless otherwise revoked in writing by patient.