Dr. Ryan L. Villwok, D.C., P.C.

New Patient Registration Form

(Please Print)

Today's date:	**Chart Number:**

Patient Information

Patients last name:	First:	Middle:	Marital Status (circle one) **Single / Mar / Div / Wid**

Nickname:	Email Address:	Birthdate: / /	Sex: □ **M** □ **F**

Street Address:	Apt #:

City:	State:	Zip:	Social Security #:

Home Phone #: ( )	Cell Phone #: ( )	Work Phone #: ( )

Occupation:	Employer:

How did you hear about our office? (please check one box): □**Dr. _____** □ **Insurance Plan**
□ **Internet** □ **Our Website** □ **Health Fair** □ **Friend/Family _____** □ **Walk-In/Drive-By**

Primary Care Physician: **May we send health updates to your PCP:** □ **YES** □ **NO**

Insurance Information

(Please give your insurance card(s) to the receptionist)

Person Responsible for bill: (First and Last Name)	Relationship to Patient: **Self / Parent / Spouse / Child**	Birthdate: / /

Is the person responsible for the bill a patient here? □ **YES** □ **NO**

Is this patient covered by medical insurance? □ **YES** □ **NO**

Please indicate your primary insurance company:

□**BCBS of NE** □**BCBS of_____** □**Cigna** □**Coventry** □**Aetna** □**UMR** □**United Health Care** □**Golden Rule**

□**QualChoice** □**Cypress Benefits** □**Medicaid** □**Medicare** □**Midlands Choice** □**Other_____**

Primary Insurers First and Last Name (**only if you are NOT primary**):

Primary Insurers Birthdate: / /	Primary Insurers Employer:

In Case of Emergency

Name of friend or relative:	Relationship to Patient:	Home Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Ryan L. Villwok, D.C. or my insurance company to release any information required to process my claims.

_____ _____

Patient / Guardian Signature **Date**

Dr. Ryan L. Villwok D.C., P.C. Office Policies

_____ **CONSENT:** I hereby request and authorize: **Ryan L. Villwok, D.C., P.C. and his staff** to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above and /or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including by not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by initialing beside and signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ **HIPAA/PRIVACY:** We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and you rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

_____ **FINANCIAL POLICIES:** It is the policy of this office to collect all co-pays and deductibles at time of service unless other arrangements have been made. We accept cash, check, Visa, MasterCard and Discover.

_____ **GROUP/INDIVIDUAL INSURANCE:** Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We offer a complimentary benefits check to verify coverage; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete and file any necessary insurance forms at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.

_____ **ASSIGNMENT AND RELEASE:** I assign directly to Dr. Ryan L. Villwok, D.C., P.C. 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 submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in the facility.

I hereby certify that I understand and agree to the policies set forth by Dr. Ryan L. Villwok, D.C., P.C.

_____ _____

Patient Name **Patient / Guardian Signature**

_____

Date