

# Charlottesville Wellness Center

## REGISTRATION FORM

(PLEASE PRINT)

Today's Date:	Primary Care Provider:
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### PATIENT INFORMATION

Patient's Full Name:			
Former/Maiden Name:			
DOB: / /	Age:	<input type="checkbox"/> M <input type="checkbox"/> F	Race:
		Marital Status:	
SSN:	Driver's License:	State:	Preferred Language:
Home Phone: ( )	Work: ( )	Cell: ( )	

### PATIENT ADDRESS

Street Address:		
City:	State:	Zip:
Mailing Address (if different from above):		
City:	State:	Zip:

### INSURANCE INFORMATION

Insurance Company:	Policy Number:	Group Number:	Effective: / /
Insurance Address:			
Secondary Insurance:	Policy Number:	Group Number:	Effective: / /
Secondary Insurance Address:			
Guarantor:	DOB:	SSN:	
Address:			
Phone: ( )	Relationship:	Employer:	

Where did you hear about us?

### IN CASE OF EMERGENCY

Name:	Relationship:
Phone 1:	Phone 2:

I authorize the use of this information on all my insurance submissions. I authorize release of information to all insurance companies. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance company. I authorize payment to be made directly to my doctor. I permit a copy of this authorization to be used in place of the original. I am aware that 24 hours notice is required for cancellations. A charge may be billed to me for a no-show. I agree to pay all costs of collection, including but not limited to agency fees. I agree to pay interest at the rate of eighteen percent per annum from and after the date of treatment, and to pay any necessary and reasonable attorney fees incurred in the collection of my account, whether or not a suit is filed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date