

# EVOLUTION

bodywork • nutrition

## REGISTRATION FORM

Today's date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security #:		Home phone #: ( )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone #: ( )		
Chose center because/Referred to center by (please check one box):				<input type="checkbox"/> Dr. <input type="checkbox"/> Bristol Total Fitness		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							
<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Do you have a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (A diagnosis code from a physician is required for treatment to be covered.)							
Please indicate primary insurance		<input type="checkbox"/> Medicare/Medicaid	<input type="checkbox"/> BCBSRI	<input type="checkbox"/> United	<input type="checkbox"/> Other		
Subscriber's name (if different):		Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:	Co-payment: \$	
Occupation:	Employer:	Employer address:			Employer phone #: ( )		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group #:	Policy #:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>IN CASE OF EMERGENCY</b>							
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone #: ( )	Work phone #: ( )		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I also authorize EVOLUTION or insurance company to release any information required to process my claims.							
EVOLUTION accepts Blue Cross and Blue Shield of Rhode Island, United Healthcare and Medicare medical insurance. Please check benefits with the insurance carrier to determine whether or not nutritional counseling is a covered service.							
Clients who wish to utilize medical insurance <u>must provide a referral or prescription from a physician for the treatment of a medical condition</u> . Proof of insurance must be provided prior to service and will be verified through the carrier. Upon verification, clients may schedule services with our center to be billed to the insurance carrier. [Prior to authorization, clients who wish to receive services will be required to make payment via cash, check, credit card or electronic transfer from a checking account.]							
The client is responsible for co-payment (if applicable) at the time of service and is also responsible for <u>any outstanding balance</u> not covered by medical insurance or co-payment. Balances are due within 30 days of service unless other arrangements have been agreed to by EVOLUTION and the patient.							
By signing below, you agree to the above and understand your financial obligation.							
_____ Patient/Guardian signature				_____ Date			