Marguerite Ruppenicker, Ph. D.

REGISTRATION FORM

Patient Information:

Name:_____Date of Birth:_____

If child, Parents names:_____

Mailing Address:_____

Physical Address (if different):_____

Phone Numbers: ☐ Cell: _____
☐ Cell: _____
☐ Home:_____
☐ Work:_____

Please check box next to number you prefer I call.

Email Address: _____

Do you have any privacy concerns when I call? _____

In case of Emergency, contact:_____Phone: _____

Primary Care Physician:_____Phone:_____

Employer/School: _____

Billing Information:

Person Financially Responsible: _____Date of Birth:_____

Relationship to patient: _____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell: _____

Employer:_____Group #:_____

Insurance Company:_____ Member #/ ID #: _____

Credit Card Number:_____Expiration Date:_____CVV_____

A credit card number is required to secure your account, and will be used for any co pays, deductibles or any other unpaid balances.

My office will contact your insurance company to verify coverage and obtain authorization when necessary. Some insurers require that you contact them directly. It is your responsibility as the policy holder to know your policy and its requirements for pre-certification, copays and benefit limits. Your medical records are protected under Federal (HIPAA) and State laws. Your written consent is required in order to release any protected health insurance and to submit claims to your insurer. Please pay copays and deductibles at the time of service.

I authorize Marguerite Ruppenicker, LLC to release information necessary to process insurance claims on my behalf.

Patient Signature:_____Date:_____

Parent or Guardian if under 18 years:_____