

**RONALD R. PARKS, M.D. PLLC**  
726 Fairview Rd, Asheville, NC 28803  
Telephone: (828) 225-1812

\* Your appointment date is on \_\_\_\_\_ at \_\_\_\_\_

**REGISTRATION FORM**

DATE \_\_\_\_\_ REFERRED BY WHOM \_\_\_\_\_

**PATIENT NAME** \_\_\_\_\_  
Last First Middle

AGE \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip Code

MAILING ADDRESS \_\_\_\_\_  
Street or box number City State Zip Code

HOME PHONE ( ) \_\_\_\_\_ DRIVER'S LICENSE NO. \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_ FAX ( ) \_\_\_\_\_ E-MAIL) \_\_\_\_\_

OCCUPATION OF PATIENT \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip Code

SPOUSE OR PARENT'S NAME OR FINANCIALLY RESPONSIBLE PARTY \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip Code

SOCIAL SECURITY NO. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DRIVER'S LICENSE NO. \_\_\_\_\_

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU (emergency information) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE NUMBER ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip Code

(PLEASE TURN OVER)

DO WE SEE ANY OTHER MEMBERS OF YOUR FAMILY? If yes, please list their names.

\_\_\_\_\_

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip Code

Guarantor's Name \_\_\_\_\_ ID# \_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip Code

Guarantor's Name \_\_\_\_\_ ID# \_\_\_\_\_

PAYMENT WILL BE BY: \_\_\_\_\_ CASH \_\_\_\_\_ CHECK \_\_\_\_\_ MASTERCARD \_\_\_\_\_ VISA  
\_\_\_\_\_ AMERICAN EXPRESS \_\_\_\_\_ DISCOVER

I understand and agree, I am a private patient, personally responsible for payment of services rendered at the Center for Integrative Medicine and Psychiatry. *The Center does not file insurance claims unless special arrangements are made with Dr. Parks.* If I am a Medicare beneficiary, I will *not* expect claims to be filed or reimbursements to be made by Medicare or my secondary insurance, as Dr. Parks is not currently participating in this program. If my account should ever be in default, I will be responsible for all legal/collection fees in addition to the balance due.

In the event that my private insurance carrier requests additional information in order to process my claims, I authorize the release of my medical or other necessary information. I understand that additional charges may be incurred for providing this information and that any amount not paid by my private insurance carrier will become my responsibility.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_