Eye Doctors OF WASHINGTON

PATIENT REGISTRATION 2010

Please Print Clearly

TODAY'S DATE: _____

Patient Name: _____ **Date of Birth:** _____
Last First MI

Age: _____ **Gender:** ☐ M ☐ F **Social Security #:** _____ **Marital Status:** S M D W P

Address: _____ **Apt#:** _____

City/State/Zip: _____

Home #: _____ **Cell #:** _____ **Work#:** _____

Employer: _____ **Occupation:** _____

Email address: _____ **Referred by:** _____

Emergency Contact: _____ **Relationship to Pt.:** _____

Emergency Phone #: _____ **Primary Language:** _____

****Please complete this section if patient is under 18 or College student****

Child's School or University: _____

Parent #1: _____	**Parent #2:** _____
Date of Birth: _____ **SS#:** _____	**Date of Birth:** _____ **SS#:** _____
Address (if different from above):	**Address (if different from above):**
_____	_____
_____	_____
Home#: _____	**Home#:** _____
Employer: _____	**Employer:** _____
Work#: _____	**Work#:** _____

Insurance Information (Please complete this section then give your insurance card(s) and photo ID to the receptionist with this form)

Primary Insurance: _____	**Secondary Insurance:** _____
ID#: _____	**ID#:** _____
Group #: _____	**Group #:** _____
Insurance Phone #: _____	**Insurance Phone #:** _____
Policy Holder's Name: _____	**Policy Holder's Name:** _____
Date of Birth: _____ **SS#:** _____	**Date of Birth:** _____ **SS#:** _____
Relationship to patient:	**Relationship to patient:**
☐Self ☐Spouse ☐Child ☐Parent ☐Other	☐Self ☐Spouse ☐Child ☐Parent ☐Other
Explain other: _____	**Explain other:** _____
ARE YOU COVERED BY A VISION PLAN? ☐VSP ☐DAVIS VISION ☐BLUE VISION ☐OTHER	***RECEPTION INITIALS***

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name *(print)* Medicare Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to *Eye Doctors of Washington*, for services furnished me by *Eye Doctors of Washington*. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. *Eye Doctors of Washington* accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to *Eye Doctors of Washington*, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** *Eye Doctors of Washington* may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to *Eye Doctors of Washington* for reimbursement for services rendered, and (2) any health care provider for continued patient care. *Eye Doctors of Washington* may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that *Eye Doctors of Washington* participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician at *Eye Doctors of Washington* currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by *Eye Doctors of Washington* if I belong to a plan with which *Eye Doctors of Washington* does not participate.

5. **NON-COVERED SERVICES:** I understand that *Eye Doctors of Washington*'s contracts with health care service plans relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient (e.g., refraction) and treatment or tests not authorized by the health care service plan.The undersigned agrees to cooperate with *Eye Doctors of Washington* to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by *Eye Doctors of Washington*, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to *Eye Doctors of Washington* for payment. I understand and agree that if my account is delinquent, I may be charged interest of 1.5% (one and one-half percent) per month, 18% (eighteen percent) per annum. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees of 33.3% (thirty-three and one-third percent) of the balance due, whether or not suit is filed. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to *Eye Doctors of Washington*. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to *Eye Doctors of Washington*. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Signature or Authorized Party Date

Relationship to Patient