New Patient Registration

Patient Information

Mr./Mrs/Ms/Dr/_____

First Name_____ MI_____Last Name_____ Jr/Sr/III/IV/_____

Date of Birth _____/_____/_____ Social Security Number _____ /____ /_____ MD/DO/DMD/CNP/____

Address _____

City _____ State _____ Zip Code_____

Do you have a second (Winter / Summer) Address? Approximate dates of use? _____

Secondary Address _____

City_____ State _____ Zip code _____

Contact Information

Home Phone_____ Cell Phone _____

Work Phone_____ Email_____

Where do you prefer to receive telephone calls? Home Cell Work

May we leave messages on your home/cell voicemail? _____ May we leave messages for you at work?_____

May we Email you? _____ Do you want to receive text reminders? _____

Patient Status

Marital Single/Married/Widowed/Other Spouse's Name _____

Employment Employed Full Time/Part Time Employer / School _____

Student Full Time/Part Time Position_____

Not Employed Retired City_____ State_____ Zip_____

Physician & Insurance

Primary Care Physician _____ City_____ State_____ Phone_____

Specialty Physician _____ City_____ State_____ Phone_____

If you have insurance, who is the insured?

Name _____ Relationship: Self / Spouse / Parent / Other_____

Address_____ City_____ State_____ Zip _____

Date of Birth___/___/____ Social Security Number_____/___/_____ Telephone _____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. A $20 (TWENTY DOLLAR) BILLING CHARGE WILL BE APPLIED TO ALL OUTSTANDING BALANCES, UNLESS PRIOR ARRANGEMETNS HAVE BEEN MADE. THE RETURNED PAYMENT FEE IS $30 (THIRTY DOLLARS). PATIENTS ARE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH COLLECTIONS AND LEGAL ACTIONS. THERE WILL BE A $30 (THIRTY DOLLAR) "NO-SHOW" CHARGE FOR NOT KEEPING APPOINTMENTS UNLESS WE HAVE BEEN NOTIFIED 24 HOURS IN ADVANCE OF THE APPOINTNED TIME.

Who may we thank for referring you? _____

Insurance Policy

Your insurance coverage is a contract between you and your insurance company. It is up to **you** to **know your policy**. Even with a referral your insurance company may not pay and your services not be covered. You will be financially responsible for services rendered if your insurance company denies payment to us. If you have any questions, please call your insurance company directly.

It is your responsibility to obtain any and all referrals. Referrals cannot be backdated, as this is insurance fraud. If you do not have a referral, and one is required by your insurance policy, **you are expected to pay for your visit at the time of service**. We will supply you with a receipt so that you may apply for reimbursement from your insurance company.

We accept assignment from many insurance companies. The companies pay a percentage of the approved amount. It is the patient's (guarantor's) obligation and the law that you pay any remaining deductible and balance between the approved amount and the amount paid by the insurance company. If for any reason your insurance company does not pay for your visit, it then **BECOMES YOUR RESPONSIBILITY**. It is your responsibility to know the contract between you and your insurance company. Please provide us with all the necessary information needed to processes your claim.

Primary Vision Insurance

Company: VSP / VBA / Eyemed / Davis _____

Insured's Name _____ Patient's Relationship to Insured : Self / Spouse / Child _____

Policy # _____ Insured's DOB:_____ SS #_____

Secondary Vision Insurance

Company: VSP / VBA / Eyemed / Davis _____

Insured's Name _____ Patient's Relationship to Insured : Self / Spouse / Child _____

Policy # _____ Insured's DOB:_____ SS #_____

Primary Medical Insurance

Company: Horizon / Medicare / Aetna _____

Plan Name _____ Policy # _____ Group #_____

Patient's Relationship to Insured Self / Spouse / Child / Oher _____

Insured's Name _____ Insured's DOB:_____SS#_____

Secondary Medical Insurance

Company : _____

Plan Name _____ Policy # _____ Group #_____

Patient's Relationship to Insured Self / Spouse / Child / Other _____

Insured's Name _____Insured's DOB:_____SS#_____

We will directly bill your insurance company as a courtesy to you only when the below criteria have been met:

1. Benefits must be verified by our office **prior** to any service.
2. Patient liability must be paid at time services are rendered.

For those companies that we do not have a contract with, payment for services must be **paid for in full** at time of service.

I have read, understand and will comply with the above mentioned Insurance Policies.

Signature _____ Date _____

insurance companies state that we must have on file your signature for release of records and authorizing payments. Please sign and date in the boxes below.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim for services rendered. I also request payment of benefits to either myself or the party who accept assignment of benefits

Signature _____ Date _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical/optical benefits to Elite Eyecare Associates/Dr. J. Scot Ellis, O.D. for Optometric and Optical Services

Signature _____ Date _____