

**PATIENT REGISTRATION
EYE CLINIC, P.C.**

ACCT # _____ DR. _____ REASON _____ TIME _____ DATE _____

PATIENT INFORMATION

LAST NAME: _____ FIRST: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ RACE: Black, White, Other

BIRTHDATE: ___/___/___ SS #: _____ M/F MARITAL STATUS: S M D W

EMPLOYER: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

RESPONSIBLE PARTY: _____ SS #: _____

RESPONSIBLE PARTY EMPLOYER: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____ PRE-CERT #: _____

POLICY HOLDER: _____ DOB: ___/___/___

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____ PRE-CERT #: _____

POLICY HOLDER: _____ DOB: ___/___/___

OTHER INFORMATION

EMERGENCY CONTACT: _____ PHONE #: _____

AUTHORIZATION TO RELEASE INFORMATION / ASSIGNMENT OF INS. BENEFITS

I HEREBY AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, DENTIST OR PHARMACIST TO RELEASE ANY INFORMATION REQUESTED REGARDING THE PROCESSING OF MY INSURANCE CLAIM, AND ALSO I DO HEREBY AUTHORIZE DIRECT PAYMENT TO THE ABOVE PHYSICIAN FOR ALL BENEFITS PAYABLE UNDER MY POLICY, WHICH I UNDERSTAND WILL BE CREDITED TO MY ACCOUNT. I WILL BE FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY. IT IS ALSO AGREED THAT IN CASE OF PAYMENT DEFAULT AND THIS ACCOUNT IS PLACED IN THE HANDS OF A COLLECTOR OR ATTORNEY ALL COSTS, COLLECTION FEES AND ALL OTHER EXPENSES WILL BE PAID BY THE UNDERSIGNED.

MEDICARE PATIENTS

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under the Medicare program standards, Medicare will deny payment for that service. We believe that, in your case, Medicare is likely to deny payment for the following noncovered services.

ATTENTION

NORMAL EYE EXAMINATION, PRESBYOPIA, AMBLYOPIA, HYPEROPIA, MYOPIA, REFRACTIONS, AND OTHERS AFTER CATARACT SURGERY MEDICARE WILL ALLOW FOR NO MORE THAN ONE PAIR OF EYEGASSES OR CONTACT LENS. MEDICARE WILL NOT PAY FOR THE REPLACEMENT OF EYEGASSES OR CONTACT LENS.

SIGN X _____ DATE _____

PATIENT / GUARDIAN / GUARANTOR