

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 ARRANGEMENTS 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 APPOINTED 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 process 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 / Other _____
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 _____