EYECARE REGISTRATION

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Parent(s) Name if Minor _____

Sex: ❑ M ❑ F Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Home Phone _____

Work Phone _____

Spouse's Name _____

In case of emergency, contact _____

Phone _____

Whom may we thank for referring you? _____

E-mail address _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Subscriber Name _____

Subscriber Birthdate _____

Subscriber SS# _____

Subscriber Relationship to Patient _____

Additional Insurance _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Elkader Eye Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Date

3 MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Elkader Eye Clinic for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration 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 HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co insurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient Signature Date

4 ACCOUNT INFORMATION

Your account is payable by cash, check, or credit card. Payment in full on dispensing. Please present any insurance cards/forms or vision care cards to the receptionist. It is your responsibility to notify us if you have any insurance or vision care plans. Insurance or vision plan cards must be presented prior to your exam and the ordering of materials or they may not be accepted. Delinquent accounts (90 days past due) subject to minimum $3.00 monthly billing fee.

Update: Date _____ Signature: _____

Update: Date _____ Signature: _____

Update: Date _____ Signature: _____

Update: Date _____ Signature: _____

Update: Date _____ Signature: _____

Update: Date _____ Signature: _____

ACKNOWLEDGMENT

I acknowledge that on _____ day of _____, 20____, I was offered/received a copy of the Elkader Eye Clinic's and the West Union Eye Clinic's Notice of Privacy Practices.

Dated this _____ day of _____, 20____.

_____

Or _____

Legal Guardian or Personal Representative
[or other relationship]