PATIENT REGISTRATION

Patient's Name: Last ________________________ First ________________________ MI ______

Address ______________________________ City________________ State ______ Zip ______

SS# ______________________ Date of Birth ___________________ Age _______ Sex _______

Race ☐American Indian ☐Asian ☐Black/African American ☐Caucasian/White ☐Multiracial ☐Decline

Language ☐English ☐Spanish ☐Other ☐Not Reported | Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino

Email __________________________________ Referred By _____________________________

Phone: Home _____________________ Cell ___________________ Work __________________

Employer ______________________________ Occupation ____________________________

Responsible Party/Guarantor of Minor (If different from above)

Name _________________________________ DOB ___________ SS# ____________________

Address _______________________________City ________________State______Zip_______

Phone: Home _____________________ Cell ____________________ Work ________________

PRIVATE HEALTH INFORMATION: I agree and give Medical Eye Associates consent to disclose my Private Health Information including treatment, billing, and appointment date/time to the individuals listed below.

Name__________________________ Relation__________________ Phone ________________________

Name __________________________ Relation__________________ Phone________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits to be made directly to Medical Eye Associates, PA for services provided to me. I understand that there may be changes incurred by me that are considered a non-covered charge by Medicare and/or private insurance. I understand that I AM FINALLY RESPONSIBLE FOR THESE NON-COVERED CHARGES. I authorize refund of overpaid insurance benefits where my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

MEDICARE PATIENTS: I am responsible for the Medicare deductible and 20% of what Medicare covers, also 100% of non-covered services. **Refractions are not a covered service by Medicare. You are responsible for this charge of $30.00.**

Patient Signature ____________________________________ **Date** ______________________

Signature of Parent/Legal Guardian ____

(circle one)