

Eye Physicians & Surgeons, LTD.
NEW PATIENT REGISTRATION
Payment is Expected For Services Rendered

Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone # () _____ Work phone #() _____

Date of Birth: _____ Sex :M ___ F ___ Social Security # _____ - _____ - _____

Marital Status: Married: _____ Single: _____ Other: _____ Age: _____

Employer: _____ Employed: _____ Retired: _____

Student: _____ Full time: _____ Part Time: _____ School: _____

Emergency Contact Person: _____ Phone # () _____

Personal Primary Physician: _____

Who referred you to our office? _____

Insurance Information

Last name of Policy Holder: _____ First: _____ MI: _____

Address _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security # _____

Policy Holder's Phone # () _____ Employer _____

Relationship to Policy Holder: Self _____ Spouse _____ Dependent _____

Primary:

Secondary:

Name: _____

Name _____

Insured: _____

Insured _____

ID# _____

ID# _____

Grp.# _____

Grp. # _____

The information below is good for 12 months following the date signed.

On an advisory from the American Academy of Ophthalmology, it is necessary to document the fact that you have been advised about the blurring of vision that may occur because of the dilation drops used to examine your eyes. These drops may make both walking and driving more difficult or dangerous.

Not to dilate your eyes may result in an inadequate examination. The need for dilation is based on the judgment of the Physician.

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Eye Physicians and Surgeons,LTD.
Signature on File, Assignment of Benefits, Financial Agreement

Patient Name (Print)

Account Number

1. **MEDICARE**-I request that payment of authorized Medicare benefits be made on my behalf to Eye Physicians and Surgeons, Ltd., for services furnished to me by Eye Physicians and Surgeons, Ltd. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly 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 CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Physicians and Surgeons,Ltd. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP**- I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eye Physicians and Surgeons, Ltd., if possible or otherwise to me.
3. **RELEASE OF INFORMATION**- Eye Physicians and Surgeons, Ltd. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Eye Physicians and Surgeons, Ltd. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Eye Physicians and Surgeons, Ltd. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE**- I understand that Eye Physicians and Surgeons, Ltd. maintains a list of healthcare service plans with which it contracts. A list of such plans is available from the business office. And that Eye Physicians and Surgeons , Ltd, has no contract , expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Eye Physicians and Surgeons , Ltd. if I belong to a plan that does not appear on the above mentioned list.
5. **NON-COVERED SERVICES**- I understand that Eye Physicians and Surgeons contracts with health care services plans (i.e., HMO's,PPO's) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility items or services, which are determined by the health care service plans not to be covered. Examples of non- covered services include , but are not limited to, services not specified as being covered in the patient's contract with a healthcare service plan , or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Eye Physicians and Surgeons,Ltd. to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT**- I agree that in return for the services provided to the patient by Eye Physicians and Surgeons, Ltd. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eye Physicians and Surgeons, Ltd. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be sent to a collection agency. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Eye Physicians and Surgeons, Ltd. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Physicians and Surgeons, Ltd. However, it is understood that the undersigned And/or the patient are primarily responsible for the payment of my bill.
7. **MEDICAL ASSISTANCE**- I understand that Eye Physicians and Surgeons,Ltd. does not participate with any medical assistance (i.e. Access, Gateway, Medplus, UPMC for you) I agree that in return for the services provided to the patient by Eye Physicians and Surgeons, Ltd.I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eye Physicians and Surgeons, Ltd. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent , I may be sent to a collection agency. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Eye Physicians and Surgeons, Ltd. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Physicians and Surgeons. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient or Authorized Signature

Date