PATIENT REGISTRATION SHEET

Last: _____ First: _____M.I.: ____SS#:_____

Date of Birth: _____ Sex: M F E-Mail Address**:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Which number do you prefer to be contacted at (circle one): Home Work Cell

Primary Physician: _____ Marital Status: Single Married Divorced Widowed

Emergency Contact: _____ Emergency Contact Phone: ( ) _____

Responsible Party (If not patient): _____ Relationship to patient: _____

Responsible Party's Phone: ( ) _____

Employer: _____ Occupation: _____

How Did You Hear About Us: _____

Race: (Select one or more)
! American Indian or Alaska Native ! Asian ! Black or African American ! Native Hawaiian/Pacific Islander ! White ! Other ! Decline to specify ! Unknown / Declined to Report

Ethnicity: ! Hispanic or Latino ! Not Hispanic or Latino

Preferred Language: ! English ! Spanish ! Other (please list) _____

INSURANCE INFORMATION: Please list the policy holder if other than the patient

Medical Insurance:

PRIMARY: _____
Policy#:_____

Subscriber Name:_____ Relationship to Patient:_____ Subscriber DOB:_____

SECONDARY: _____
Policy#:_____

Subscriber Name:_____ Relationship to Patient: _____Subscriber DOB:_____

Vision Insurance: _____
Policy#:_____

Subscriber Name:_____ Relationship to Patient: _____Subscriber DOB:_____

REFRACTION FEE

A refraction is a test or procedure performed to determine how well a person sees and is performed as part of an eye exam to determine and follow the health of the eyes and, sometimes for the purpose of prescribing eyeglasses. I understand that the refractive service that I receive is considered a non-covered benefit by Medicare and most Private insurances. I also understand that it is a separate charge not billable by most medical insurance. The refraction fee is $40 and due at time of service, **whether or not it results in a prescription for eyeglasses**.

FINANCIAL AGREEMENT

I understand that it is my responsibility to provide accurate insurance information at every visit in order for my claim to properly filed. If I do not provide the proper insurance information, I understand that I will be responsible for payment in full.

I request payment of authorized insurance benefits be made on my behalf to Chico Eye Center for services furnished to me by Chico Eye Center. I authorize any holder of medical information about me to release to the Health Care. 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, my signature authorizes releasing the information to the insurer or agency shown. Financing Administration and its agents any information to determine the benefits payable for related services.

I understand that it is my responsibility to pay any deductibles, copays, coinsurance or other balances not paid by my insurance company. I understand that all patient responsible amounts are due at time of service. I agree that in return for the services provided to the patient by Chico Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Chico Eye Center 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 charged interest at the legal rate.

However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Relationship of Representative to Patient