

PATIENT REGISTRATION FORM

DOMINION EYE CARE

Date: _____

First Name		MI	Last Name		Sex
Home Address			City	State	Zip Code
Home Phone		Work Phone		Cell Phone	
Date of Birth	Age	Social Security Number	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		E-mail Address
Patient Employer / Occupation (indicate if student)		Financially Responsible Person <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		Name (if different from patient)	
Financially responsible persons address (if different from patient)			Home phone	Work phone	
Is patient residing in Skilled Nursing Facility? <input type="checkbox"/> yes <input type="checkbox"/> no		If yes, name and address of facility			Facility phone number
Emergency Contact		Relationship		Phone number	
Referring Physician			Phone number		
Primary Care Physician			Phone number		

INSURANCE INFORMATION

Primary Insurance:

Carrier: _____ Address: _____ Phone: _____

ID# _____ Group # _____ Effective Date: _____

Policyholder: _____ Policyholder SSN: _____ DOB: _____

Secondary Insurance:

Carrier: _____ Address: _____ Phone: _____

ID# _____ Group # _____ Effective Date: _____

Policyholder: _____ Policyholder SSN: _____ DOB: _____

Tertiary Insurance:

Carrier: _____ Address: _____ Phone: _____

ID# _____ Group # _____ Effective Date: _____

Policyholder: _____ Policyholder SSN: _____ DOB: _____

ACCOUNT NUMBER: _____

FINANCIAL POLICY STATEMENT

Welcome to Dominion Eye Care, P.C. We are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. We ask that you **carefully** read and sign the following policy. We must emphasize that, as your medical care provide, our relationship is with **you** and **not** your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment** thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment. You will be responsible for your payment portion at the time of service. **Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and responsibility. This includes, obtaining any referrals and/or authorizations, which your insurance company requires **before** care is provided. All co-pays, co-insurance and deductibles are due and payable at the time service is rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payments at the time services are rendered.

Should a monthly payment plan become necessary, arrangements can be made through our office. Failure to pay for services or adhere to a payment plan will result in collection action. All collection costs incurred by Dominion Eye Care, P.C., including attorney's fees, will become the sole responsibility of the responsible party named herein.

In consideration of the services performed by Dominion Eye Care, P.C. you agree to abide by the terms of this Financial Statement.

Patient /Parent Signature

Date

PATIENT'S AUTHORIZATION

I, _____, hereby authorize Dominion Eye Care, P.C. to apply for benefits on my behalf for services rendered. I request payment from Medicare and _____ be made directly to Dominion Eye Care, P.C.

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

**Patient/Parent
Signature**

Date
