

PATIENT REGISTRATION FORM

LAST NAME _____ FIRST NAME _____ M.I. _____

ADDRESS _____ CITY/STATE/ZIP _____

SS# _____ DATE OF BIRTH _____ SEX: M ___ F ___

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ FAX NUMBER _____

EMERGENCY CONTACT NAME & PHONE _____

PCP/REFERRING PHYSICIAN _____ PHONE _____

PHYSICIAN ADDRESS _____

POLICY HOLDER

PRIMARY INS. _____ NAME OF HOLDER _____

RELATIONSHIP TO PATIENT _____ PHONE # _____

ADDRESS

CITY/STATE/ZIP _____

SS# _____ DATE OF BIRTH _____

SECONDARY INS. _____ NAME OF HOLDER _____

RELATIONSHIP TO PATIENT _____ PHONE # _____

ADDRESS

CITY/STATE/ZIP _____

SS# _____ DATE OF BIRTH _____

INSURANCE INFORMATION

MEDICARE _____ PPO _____ HMO _____ INDEMNITY _____ MEDICAID _____

SELF-PAY _____ WORKER'S COMP _____ AUTO _____ VISION PLAN _____

FINANCIAL DISCLOSURE/SIGNATURE RELEASE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO WESTWOOD OPHTHALMOLOGY ASSOCIATES FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AGREE TO PAY ALL AMOUNTS NOT COVERED BY INSURANCE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR OTHER AUTHORIZED INSURANCE COMPANIES ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. IN THE EVENT MY ACCOUNT IS FORWARDED TO A COLLECTION AGENCY, A SURCHARGE OF \$50 OR 20% OF MY BALANCE, WHICHEVER IS GREATER, WILL BE ASSESSED.

PATIENT'S SIGNATURE: _____ DATE: _____

OFFICE POLICY FOR ALL PATIENTS

The doctors of Westwood Ophthalmology Associates have enrolled in numerous insurance programs so that we may satisfy the needs and requests of our patients. All insurance plans vary and in order for us to provide you with complete care from the moment you walk through our doors, we ask you, the policyholder, to be aware of your insurance plan.

Because of the intricacies of all the different insurance plans/policies, it is extremely difficult for us to keep up to date with the specific coverage and requirements of each and every plan, without your full cooperation. Please understand that each plan has different stipulations pertaining to:

- well-care vision coverage,
- refraction coverage (necessary vision testing performed by the doctor),
- referrals (which may be required according to your plan), and
- pre-existing conditions.

IT IS VERY IMPORTANT THAT YOU, THE PATIENT, COME INTO OUR OFFICE WITH ALL OF THE REQUIRED DOCUMENTATION AND BE FULLY AWARE OF HOW YOUR PLAN WORKS PRIOR TO THE TIME OF YOUR SCHEDULED APPOINTMENT. YOU MAY BE BILLED FOR ANY UNCOVERED SERVICES. YOU, THE PATIENT, ARE THE POLICYHOLDER AND IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN.

PLEASE BE ADVISED THAT WE DO NOT PARTICIPATE IN ANY VISION PLANS.

Giving you the best ophthalmic care is our goal; however, we need your cooperation to attain it.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY FOR ANY NON-COVERED SERVICES.

Patient Name

Date

Patient Signature/Guardian Signature