PATIENT REGISTRATION

For privacy purposes, how can we contact you? Please check all that apply.

_______ Answering Machine _______ Work _______ Friend _______ Spouse _______ Other family member
_________________________________ Other

PATIENT'S NAME: ____
First *Middle* *Last*

ADDRESS: ____
Street *City* *State* *Zip Code*

SS#: _____-_____-_____ DATE OF BIRTH: ____________________ PHONE #: ____________

PLACE OF EMPLOYMENT: ____________ ADDRESS: ____________ PHONE #: ____________

❑ FEMALE ❑ MALE NAME OF REFERRING DOCTOR ____________________
First and Last

SPOUSE: ____________ EMPLOYER: ____________ PHONE #: ____________

NEAREST FRIEND OR RELATIVE **NOT** LIVING WITH YOU. NAME: ____________________

ADDRESS: ____________ RELATIONSHIP: ____________ PHONE #: ____________

IF PATIENT IS A CHILD:
MOTHER'S NAME ____________ EMPLOYMENT: ____________ PHONE #: ____________

SS#: _____-_____-_____ DATE OF BIRTH: ____________

FATHER'S NAME ____________ EMPLOYMENT: ____________ PHONE #: ____________

SS#: _____-_____-_____ DATE OF BIRTH: ____________

DO YOU HAVE A VISION PLAN? ❑ **VSP** ❑ **SUPERIOR VISION**

INSURANCE INFORMATION

ID#: ____________

NAME OF INSURANCE: ____________________ GROUP #: ____________

INSURANCE CO-ADDRESS: ____________________ INSURED DATE OF BIRTH: ____________

NAME OF INSURED: ____________________ RELATIONSHIP TO INSURED: ____________

INSURED SS NUMBER: _____-_____-_____ INSURED EMPLOYER: ____________________

– over –

Signature on File, Assignment of Benefits, Financial Agreement

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to the Eye Group, LLC, for services furnished me by the Eye Group. LLC. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services 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. The Eye Group, LLC accepts the charge determination of the Medicare carrier, Blue Cross of Arkansas, as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

OTHER INSURANCE: I hereby authorize payment of my medical and surgical insurance benefits to Eye Group, LLC. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Group, LLC. I authorize Eye Group, LLC to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

NON-COVERED SERVICES: I understand the insurance contracts with the Eye Group, LLC relate only to items and services which are "covered" by the insurance plan.
In addition, Medicare and many insurance carriers do not cover refractions. A refraction is the routine part of the exam that determines the need for eyeglasses. The patient will be responsible for this service.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by the Eye Group, LLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Eye Group, LLC for payment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to the Eye Group, LLC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Eye Group, LLC at the time of service. In the event my account becomes delinquent, and is turned over to an outside collection agency, I understand that I will be responsible for all fees and expenses incurred on behalf of the Eye Group, LLC.

____________________________________ __________________

Beneficiary Signature or Authorized Party — Date