PATIENT REGISTRATION

Where did you hear about us? ☐ Friend ☐ Physician ☐ Internet ☐ Phone Book ☐ Other_____

Which other family members have we seen? _____

Referring Physician: _____ Phone _____

PATIENT INFORMATION

Patient's Name: _____ Email: _____
Last First Middle

Home Address: _____
Street Apt. City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

DOB: _____ Social Security #: _____ Sex: M or F Marital Status: M S D W

Employer or School: _____ If Student: Full-time or Part-time

Nearest Friend/Relative Not living with patient Name: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ Relationship to patient: _____

Home Address: _____
Street Apt. City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

DOB: _____ Sex: M or F Social Security #: _____

Employer: _____ Email: _____

Spouse: _____ DOB: _____ Social Security #: _____

Spouse Employer: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Insurance #1: _____ Policy #: _____

Name of insured: _____ DOB: _____ Relationship to patient: _____

Insurance #2: _____ Policy #: _____

Name of insured: _____ DOB: _____ Relationship to patient: _____

OTHER INFORMATION

Patient's Race: ☐ Caucasian ☐ Hispanic/Latino ☐ African American

☐ Asian ☐ Other, Please Specify _____

Patient's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Patient's Language: ☐ English ☐ Other, Please Specify _____

Insight
EYE SPECIALISTS

CHRISTIAN L. HESS, MD . TREVIN R. WALLIN, MD . MARK L. HILL, MD

Patient Name: _____ **Date of Birth:** _____

LIFETIME CONSENT AND FINANCIAL AGREEMENT

I have read, understand, and agree to the *Patient Notice of Privacy Practices*. I authorize treatment of the person named above. I authorize direct payment by Medicare and all other insurance companies to *Insight Eye Specialists*. All patient responsible portions are due at the time of service such as Medicare's 20% co-payment, refraction fees, any deductibles, co-payments, and non-covered services. I authorize the use of text messages to collect any amounts I may owe for past or current accounts and acknowledge that such calls could result in charges by my telephone carrier. I understand that if this account is sent to collections, I agree that in addition to any amount left owing to *Insight Eye Specialists*, I will be responsible for cost incurred for certified/priority mail, interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.

Your signature indicates you understand and agree to the above Consent and Financial Agreement.

X _____ _____

Signature of Patient or Responsible Party **Date**

Print Name: _____ **Date of Birth:** _____

Relationship to Patient: _____

Address/Phone if Different than Patient: _____

****

MEDICAL AND FINANCIAL INFORMATION AUTHORIZATION AND RELEASE

The purpose of this Authorization and Release form is for your protection. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I authorize *Insight Eye Specialists* to release any **FINANCIAL AND MEDICAL INFORMATION** to the following people:

Circle One or More and List Name(s): Spouse Partner Parent/Guardian Other

Name(s): _____

X _____ _____

Signature of Patient or Responsible Party **Date**