



PATIENT REGISTRATION FORM

First Name		MI	Last Name	
Home Address				Apt#
City		State	Zip Code	
Date of Birth		Gender <input type="checkbox"/> M <input type="checkbox"/> F		SS#
Home Phone#		Work#		Cell #
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		E-mail Address		Driver's License#
Patient Employer / Occupation (indicate if student)				
Financially responsible persons address (if different from patient)				
Is patient residing in Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, name and address of facility				Phone
Emergency Contact Name		Relationship		Phone
Referring Physician Name/Address				Phone
Primary Care Physician Name/Address				Phone

INSURANCE INFORMATION:

Primary Insurance				
ID#	Group #	Effective date	Subscriber Employer	
Policy Holder	Subscriber DOB		Relationship to Subscriber	Subscriber SS#
Address:			Phone#	
Secondary Insurance				
ID #	Group #	Effective Date	Subscriber Employer	
Policy Holder	Subscriber DOB		Relationship to Subscriber	Subscriber SS#
Address:			Phone#	

FINANCIAL POLICY STATEMENT

Welcome to Retina Vitreous Center, we are pleased that you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. Should your account be sent to a third party collector, you agree to pay an additional 30% of the balance or \$50, whichever is greater. A return check fee of \$35 will be assessed if your check is returned by your bank.

Patient Signature _____ **Date** _____

PATIENT AUTHORIZATION

I hereby authorize ASSOCIATED RETINAL CONSULTANTS, LLC to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and or any other insurance company be made directly to ASSOCIATED RETINAL CONSULTANTS, LLC. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare part B benefits.

Patient Signature _____ **Date** _____