Atlantic Eye, LLC

PATIENT REGISTRATION FORM

Patient's Last Name:_____ First Name:_____Middle Initial:_____

Address:_____Zip Code:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Date of Birth:_____Race: _____ SS#: _____

Gender:_____ Marital Status: S M D W Email Address:_____

Emergency Contact Name:_____Relationship:_____Phone:_____

Primary Care Physician Name: _____Phone:_____

(RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT OR IF PATIENT IS A MINOR)

Name:_____Relationship:_____ Date of Birth:_____

Address:_____Phone Number:_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____ Name of Policy Holder:_____

Policy #:_____ Group#: _____

Relationship: _____Date of Birth:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____ Name of Policy Holder:_____

Policy #:_____ Group#: _____

Relationship: _____Date of Birth:_____

How did you hear about the practice? (if a specific person-please provide the person's name) TV, Newspaper, Radio, Internet?

_____

Signature:_____Date:_____

Office Use Only: Acct#:_____

FINANCIAL POLICIES AND AGREEMENT

- **Financial Policy**: In order to control billing costs, Atlantic Eye, LLC requests that all deductibles, co-insurances and co-payments for office visits, tests, or procedures be paid at the conclusion of each visit. Many insurance companies pay fixed allowances for services and other companies pay a percentage of the service**. It is the patient's responsibility to pay all balances not covered by insurance companies.** Atlantic Eye, LLC reserves the right to charge your account a statement fee for any balance that has to be collected after the date of service. All collection fees or attorney fees associated with past due accounts will be added to your balance.

- **Medicare / Health Insurance Authorization**: I request that the payment of authorized Medicare and/or insurance benefits be made on my behalf for any services provided to me. I authorize the release of all medical information about me to the Centers for Medicare and Medicaid Services (CMS) or any other insurance carrier I may have in order to determine the benefits payable for services I have received or that I am considering.

- **Cancellation/No Show Policy:** If an appointment is not cancelled at least twenty-four hours (24) in advance or if a patient does not show for their scheduled appointment, Atlantic Eye, LLC will charge a $25.00 fee. This fee is not covered by insurance.

- **Refractions**: Part of a good eye exam includes a check of your vision (or visual acuity) in each eye. If your vision with your current eyeglass prescription is anything less than 20/20, which is normal or "perfect vision", a reason for your reduced vision needs to be determined. The first step is to update the eyeglass prescription to determine whether a change in your prescription would restore your eyesight to 20/20. **Most insurance companies including Medicare *DO NOT* reimburse for refractions or to update your eyeglass prescription.** This service is considered "routine" and therefore is not a covered service. **The charge for the refraction is $49.00 and is payable at the time of service.** Refusal to have this service if it is deemed necessary may result in your appointment being rescheduled or cancelled.

- **Late Arrival**: If a patient is more than fifteen (15) minutes late for an appointment, Atlantic Eye, LLC reserves the right to reschedule the appointment or to see the patient when the schedule permits.

- **Medical Payment Release of Information**: I hereby authorize Atlantic Eye, LLC to release all information necessary to secure proper reimbursement to my insurance company or any necessary third party.

Co-pays, co-insurances, and deductibles quoted to me are ESTIMATES based on information provided to Atlantic Eye for reimbursement by my insurance company.
I understand I am financially responsible for all charges provided to me by Atlantic Eye, LLC that are NOT reimbursed by my insurance company.

Patient's Printed Name: _____Date:_____

Patient's Signature:_____

Office Use Only: Account #:_____

REV 5/4/16