Chili Vision Group

Patient Registration Information Sheet

Today's Date:_____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone:_____ Cell Phone: _____ Birth Date: _____

E-Mail Address: _____

Gender: M F Social Security #: _____

Marital Status: _____M(Married) _____S(Single) _____W(Widowed) _____D(Divorced)

Employer: _____ Work Phone: _____

Name of Primary Doctor:_____ Phone: _____

Name of Previous Eye Doctor (if new patient): _____

Is the patient responsible for the bill? YES NO

If NO, please put name of the person responsible:_____ Birth Date: _____

Insurance Information

Insurance Company 1: _____ Policy #:_____
(Please write number exactly as it appears on the card. Also include any prefix or suffix.)

Financial Assignment and Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge.
   It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid by your insurance.
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release the **Health Care Financing Administration**, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related service.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by all said insurances. I hereby authorize said assignee to release all information necessary to secure the payment.
4. Patient agrees to accept responsibility for any cost related to collecting past due amounts including collection and attorney fees.

Signed (patient - or parent, if minor):_____ Date:_____

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Contact Lenses

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Refractive Surgery Co-Management

Dry Eye Therapy

Optical

Acknowledgement of Receipt and General Consent

I acknowledge that I received a copy of the CHILI VISION GROUP'S Notice of Private Practices.

I further consent to the release of my health information for the purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patient Name (please print): _____

Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____

Name (please print): _____

Source of Authority: _____