Eye Clinic of Edmonds

REGISTRATION FORM

PATIENT INFORMATION

Last name: **First:** **Middle:** **Social Security #:**

Preferred Name: **Emergency contact name/relationship:** **Emergency contact phone #:** ( ) **Birth date:** **Sex:** ❑ M ❑ F

Mailing address: **City:** **States/Zip:**

Home phone #: ( ) **Cell phone #:** ( ) **Work phone #:** ( ) **Primary Language:**

Occupation:

Race:
❑ White ❑ Black or African American
❑ Asian ❑American Indian ❑ Other

Ethnicity:
❑ Hispanic or Latin
❑ Not Hispanic or Latin

Email:

INSURANCE INFORMATION

Your insurance card(s) and photo ID are required when you check in with the front desk.

**** Please be advised: if you are using your insurance coverage for today's visit, this is a contract between you and your insurance company, not The Eye Clinic of Edmonds. **If your `insurance company requires a referral for medical visits, you are responsible for obtaining this referral from your primary care doctor prior to being seen in our office.** Insurance typically does NOT cover contact lens evaluations or fitting fees, see the attached contact lens document for further details regarding our policies on contact services and fees.****

Primary Insurance name: Identification/Policy #: Group #: Does this plan have a SEPARATE vision vendor?

Subscriber's name: Subscriber's date of birth: Subscriber's social security #: Subscriber's Occupation/Employer:

Secondary Insurance name: Identification/Policy #: Group #: Does this plan have a SEPARATE vision vendor?

Subscriber's name: Subscriber's date of birth: Subscriber's social security #: Subscriber's Occupation/Employer:

FINANCIAL AGREEMENT

Thank you for choosing The Eye Clinic of Edmonds for your eye care needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policies.

- **ALL COPAYS ARE DUE PRIOR TO SEEING THE PHYSICIAN.**
- **THE REFRACTION FEE OF $80.00 IS COLLECTED AT THE TIME OF SERVICE** IF WE HAVE ALREADY DETERMINED THAT YOUR INSURANCE DOES NOT COVER THIS SERVICE. **MEDICARE DOES NOT PAY FOR THE REFRACTION CHARGE.**
- **UNLESS WE ARE BILLING YOUR INSURANCE, A MINIMUM DEPOSIT OF $100.00 IS DUE AT THE TIME OF SERVICE.** FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECK, VISA MASTERCARD, AMERICAN EXPRESS AND DEBIT CARDS. IF YOU ARE UNABLE TO MAKE THIS PAYMENT, WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.
- **RETURNED CHECKS ARE SUBJECT TO A $25 RETURNED CHECK CHARGE.**

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for any non-covered service(s) including deductibles and copays. I am also aware that I am responsible for any costs incurred in collection of any non-assigned fees. I authorize the physicians of The Eye Clinic of Edmonds to release any information required to process my insurance claims. I acknowledge that I am aware of or received a copy of The Eye Clinic of Edmonds Notice of Privacy Practices.

Patient/Guardian signature *Date*

Things to Be Aware of For Your Appointment: Office Policies

- In addition to requiring your photo ID upon arrival as new patient, we will be taking a picture of you for your electronic records.
- Please familiarize yourself with your medical/vision insurance plans, we do our best to check on your eligibility prior to your appointment, but we are not always able to obtain this information. YOU are responsible for the charges incurred at your visit and must be aware of your coverage and/or your need for referral or prior authorization. You may need to contact your primary care doctor for your referral.
- **Medicare (as well as several other insurances) does NOT cover refractions. A refraction is the portion of the eye exam which determines your glasses prescription. If you are having your eyeglasses prescription updated and your insurance does not cover the refraction, it is our policy to collect the associated fee of $80 at the time of service.**
- Routine Eye Exams can last 1-2 hours, please allow adequate time for this appointment. Medical appointments can last anywhere from 20-90 minutes and occasionally longer if the purpose of your visit is of a surgical nature. Once again, we ask that you arrange your schedule to that you will not be rushed when you come to see us, this will enable us to best serve your eye care needs.
- You may be dilated during your appointment with us, this can cause blurred vision when reading and increased light sensitivity. Please bring sunglasses with you, but if you do not have any, a disposable pair will be provided for you. Be sure to bring all prescription glasses and contacts to your appointment, we cannot evaluate whether your glasses prescription has changed or adequately check your vision without your current glasses on hand.
- Please complete and return all Registration Documents at least **15 minutes prior** to your scheduled appointment time so that we may process your paperwork, insurance cards, photo ID and copays.
- If you have any questions, please feel free to **call our office at 425.774.7723** Thank you!

Authorized Recipients of Healthcare Information

We keep a record of the healthcare services we provide to you. You may ask to see a copy of that record; you may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. We do require at least **twenty-four hours prior notice** to prepare your record and there may be a **fee associated with copying your records for you.** We also wish to inform you that our front office staff will send out a notice via email or call you on the day prior to your scheduled service date to remind you of your appointment with us unless you request us not to. **Please list below any individuals you authorize to have access to your health information and their relationship to you.**

Name:	**Relationship:**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

______________________ ______________________

Patient/Guardian Signature **Date**