Rosin Eyecare Confidential Internal Patient Registration Form

Patient Information

Name:( )_____ Today's Date:_____
(Title) First Middle Initial Last

Address:_____ Birthdate:____/____/_____

_____ SSN:_____-_____-_____
City State Zip Code

Home Phone # _____/_____/_____ Daytime Phone # _____/_____/_____ Cell Phone # _____/_____/_____

E-Mail Address:_____ Occupation:_____ Gender: M / F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Self-Employed ☐ Unknown

Employer: _____

Referred By: ☐ Walk In ☐ Recall ☐ Insurance Company ☐ Phone Book _____
Referral Persons Name

☐ Internet ☐ Coupon /Mailer ☐ Employee ☐ Patient ☐ Professional

Emergency Contact Person _____
Best Contact # _____/_____/_____ wk / cell / home

Preferred Language: English Spanish Other_____
Race: Am Indian Asian African American Hispanic Caucasian
Ethnicity: Hispanic/Latino Native Hawaiian/Pacific Not Hispanic

Insurance Information

Relationship To Insured Party:
☐ Self
☐ Spouse
☐ Dependent Child
☐ Other _____

Vision Insurance: _____
Medical Insurance: _____
Employer Name:_____
Primary Card Holder Name: _____
Birthdate of Primary Card Holder: ____/____/_____
ID # or SS # _____ Group # _____

Person Responsible for Payment (if minor)

_____

Primary Card Holder Address (if differs from above)

_____

Secondary Insurance Name: _____
ID # : _____

_____

Rosin Eyecare Financial Responsibility

Thank you for choosing Rosin Eyecare for your eyecare needs. We are happy to serve you, and look forward to a long relationship with you, our valued patient. In an effort to serve you efficiently, we have instituted the following financial policy. This policy below outlines the understanding between you, the patient and our office. Our office will, as a courtesy, file insurance claims based upon the information you have provided us, if we are a participating provider in your insurance plan. It is your responsibility to provide us with complete and accurate information. You will be asked to provide this information on an annual basis. Failure to provide information necessary and required by your insurance company will result in denial of your claim. Insured parties are expected to know their plan requirements and abide by any specifications of their insurance plan. Furthermore, if your insurance company requests information from you, you must provide that information promptly. If your claim is denied, it becomes your responsibility to pay the balance in full. By signing below, you understand that you will be responsible for payment of any services not paid by your insurance company which included co-payments, deductibles, coinsurance and non-covered items, and denied services not covered by contract between our office and your insurer. We will assist you in any way possible to be sure that the claim is handled properly; we will file our insurance claim for you, and send you a reminder statement when there is a balance to be paid by you. In instances where it is deemed necessary, we reserve the right to refer uncollected balances to an outside collection agency. By keeping lines of communication open and providing accurate information, you can be sure that your claims will be handled promptly and efficiently.

Rosin Eyecare requires that all exam fees and copays be paid in full at time of service, and a deposit of 50% when ordering materials. Thank you in advance for your cooperation.

By signing below, I agree that I am ultimately responsible for payment of services provided to me. My signature below authorizes Rosin Eyecare to release the information necessary to facilitate the payments of eyecare claims.

Signed:_____ **Date**:_____/_____/_____ PRF7-8-08.KO

Updates: Initials_____ Date_____ Initials_____ Date_____ Initials_____ Date_____