

# Cascade Eye & Skin Centers, P.C.

Patient Account #

## PATIENT REGISTRATION FORM

Today's Date		First		MI	Last			
Nickname		Gender	Marital Status		Birth date	Age	S.S. #	
Address				City		State	Zip	
Employed By			Employers Phone		Occupation			
Home Phone			Cell Phone/Pager			E-Mail		
Emergency Contact Name			Emergency Phone			Spouse Name		
Are you a student? ( <input checked="" type="checkbox"/> one) <input type="checkbox"/> Yes <input type="checkbox"/> No					If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time			Name of School

### CONSULTATION INFORMATION

If another Physician referred you to our office, please provide the following information:

Do you have a written request for this consultation? ( one)  Yes  No  Did not bring

Name of Physician:

Phone Number:

If you were not referred by another Physician, how did you hear about our office?

 Phone book  TV  Patient  Internet  Mailing  Newspaper  Other: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

First		MI	Last			
Home Phone		Gender	Marital Status			
Address			City		State	Zip
Birth date	Social Security Number		Employed by			

### PRIMARY INSURANCE INFORMATION

**NOTE:** Please provide your complete insurance information. Include **BOTH MEDICAL AND VISION** coverage. We also require a copy of your insurance card to be scanned into your account in order to ensure accuracy.

Name of Insurance		Subscriber Name (Last, First)			Subscriber DOB
Relationship to Patient	Co-Pay \$	Subscriber Identification #		Group #	

### OTHER INSURANCE INFORMATION

Name of Insurance		Subscriber Name (Last, First)			Subscriber DOB
Relationship to Patient	Co-Pay \$	Subscriber Identification #		Group #	

**PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT**

# PLEASE READ AND SIGN

I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim. If I am private pay, I understand that payment is due at time of service. I also give my consent for examination and treatment as necessary.

## FOR MINOR CHILDREN

If the patient is a minor, Cascade Eye & Skin Centers, P.C. has permission to treat and/or dilate my child.

## OFFICE PAYMENT POLICY

Payment is expected at the time of service unless other arrangements have been made in advance. Exceptions to this include those insurance companies for which we are preferred providers. We will bill these insurances for you; however, any co-payments or deductibles are due at the time of service. Cascade Eye & Skin Centers, P.C. accepts Medicare assignment for all Medicare patients. All balances are due in full within 30 days. All outstanding accounts will have a \$5.00 rebilling fee added after 30 days.

## PRIVACY POLICY

Federal law requires that the Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, be made available to patients. This law also requires that each individual acknowledge that you have been advised of the policy.

You have the right to review our notice, and if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request.

Your signature acknowledges that you have received or have been offered and refused, a copy of our Notice.

Information regarding my healthcare may be released to the person(s) listed below:

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

I have read and understand all of the policies listed above.

Patient / Guardian Signature:

Print Patient Name:

Date: