

# Cascade Eye & Skin Centers, P.C.

## PATIENT REGISTRATION FORM

Today's Date	First	MI	Last		
Nickname	Gender	Marital Status	Birth date	Age	S.S. #
Preferred language	Race	Ethnicity			
Address	City	State	Zip		
Home Phone	Cell Phone/Pager	Work Phone			
Employed By	Emergency Contact Name	Emergency Phone			
Are you a student? ( <input checked="" type="checkbox"/> None) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	E-Mail				

### PRIMARY CARE PHYSICIAN / REFERRING PROVIDER INFORMATION

Primary Care Physician Name:	Phone Number: ( )
Address:	
Referring Provider Name:	Phone Number: ( )
Address:	

### 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other	Co-Pay \$	Subscriber Identification #	Group #

### OTHER INSURANCE INFORMATION

Name of Insurance	Subscriber Name (Last, First)	Subscriber DOB	
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other	Co-Pay \$	Subscriber Identification #	Group #

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

Print Patient Name:

Date of Birth:

## 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 co-pays are due at the time of service. There will be a \$20.00 billing fee for any co-pays not paid at time of service.**

### NO SHOW POLICY

#### Office Visits

There will be a \$30.00 fee assessed to all patients who no shows for an office visit.

#### Clinical Surgeries

There will be a \$50.00 fee assessed to all patients who no show for a surgery scheduled in the clinic.

### 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: