CASCADE EYE & SKIN CENTERS, P.C.- PATIENT REGISTRATION FORM

PATIENT INFORMATION- IF A MINOR CHILD, MUST COMPLETE RESPONSIBLE PARTY SECTION

FIRST	M.I.	LAST

BIRTH DATE	AGE	MARITAL STATUS	SOCIAL SECURITY NUMBER	GENDER

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS

EMPLOYER	PREFERRED LANGUAGE	RACE	ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC

RESPONSIBLE PARTY- ***IF MINOR CHILD, THIS IS THE PERSON BRINGING TO APPOINTMENT*** **– NOT THE INSURED**

FIRST	M.I.	LAST

BIRTH DATE	AGE	MARITAL STATUS	SOCIAL SECURITY NUMBER	Gender

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER

INSURANCE INFORMATION

NAME OF INSURANCE- ***primary***	SUBSCRIBER NAME	SUBSCRIBER D.O.B.

RELATIONSHIP TO PATIENT	SUBSCRIBER #	GROUP NUMBER
☐ SELF ☐ PARTNER ☐ CHILD ☐ SPOUSE ☐ OTHER ☐ P.O.A		

GENDER	EMPLOYER

NAME OF INSURANCE- ***secondary***	SUBSCRIBER NAME	SUBSCRIBER D.O.B.

RELATIONSHIP TO PATIENT	SUBSCRIBER #	GROUP NUMBER
☐ SELF ☐ PARTNER ☐ CHIL ☐ SPOUSE ☐ OTHER D		

GENDER	EMPLOYER

CONTACT INFORMATION

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

EMERGENCY CONTACT NAME	D.O.B. (optional)	EMERGENCY CONTACT PHONE

WOULD YOU LIKE TO BE ADDED TO OUR MAILING LIST?	HOW DID YOU HEAR ABOUT US?
☐ E-MAIL ☐ ALREADY ON LIST	

Print Patient Name: **Date of Birth:** **Account Number:**

CASCADE EYE & SKIN CENTERS, P.C.
OFFICE & PRIVACY POLICIES

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.

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. Co-pays are due at the time of service, there is a $20.00 billing fee for any co-pays not paid at time of service.
All balances are due in full within 30 days.
Cascade Eye & Skin Centers, P.C. accepts Medicare assignment for all Medicare patients.

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 & Cosmetic Appointments
There will be a $50.00 fee assessed to all patients who no show for a surgery or cosmetic appointment 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: _____

In addition, to remain compliant with HIPAA policies and procedures we ask for permission to leave detailed messages regarding the following:

- Medications & Treatment
- Billing and Insurance questions / concerns
- Labs & Pathology results
- Scheduling

Check how / who we can leave these messages with below:

☐ PATIENT PHONE NUMBER ON FILE _____
☐ SPOUSE OR SIGNIFIGANT OTHER _____
☐ FAMILY MEMBER _____
☐ OTHER _____
☐ DO NOT LEAVE DETAILED MESSAGES

I have read and understand all the policies listed above.

PRINT PATIENT NAME	PATIENT OR GUARDIAN SIGNATURE	DATE