CHESTER COUNTY EYE CARE

(610) 696-1230
CHESTERCOUNTYEYECARE.COM

Patient Registration Form

PATIENT INFORMATION					
Last Name	First	MI	Female ( ) Male ( )	Birth Date	
Address	Apt #	City	State	Zip	
Home Phone #	SS #	Occupation	Marital Status		
Work Phone #	Cell Phone #	E-Mail			
Primary Care Physician	Referring Doctor	Pharmacy Name & Phone #			
Employer Name/Address	City	State	Zip		
Emergency Contact	Relationship	Phone #			

INSURANCE			
Primary Insurance – Name & Address			
Policy #	Group #	Effective Date	
Policy Holder Name	DOB	SS #	
Relationship to Patient	Employer		
Secondary Insurance – Name & Address			
Policy #	Group #	Effective Date	
Policy Holder Name	DOB	SS #	
Relationship to Patient	Employer		

WKMN COMP			
Is this work related? ( ) Y ( ) N	Date of Injury	Claim #	
Workmans Comp. Insurance & Address			
Attorney Name & Address			

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

ASSIGNMENT OF BENEFITS:

I hereby assign or transfer payment benefits made to me and by behalf to Chester County Eye Care Associates, P.C. for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

RELEASE OF INFORMATION:

I hereby authorize Chester County Eye Care Associates, P.C. to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor, or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

[PLEASE READ AND SIGN REVERSE SIDE OF THIS FORM]

PATIENT FINANCIAL RESPONSIBILITY POLICY FORM

Thank you for choosing Chester County Eye Care Associates as your eye care provider. We are honored by your choice and are committed to providing you and your family with the highest quality eye care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

INSURANCE COVERAGE
It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance company. If your insurance requires a referral, it is your responsibility to obtain one prior to your visit. If you do not have one, you may sign a waiver stating that you will be responsible for payment in full if the referral is not received within one day. Alternatively, you may reschedule your appointment.

Just as we make every effort to accommodate you when you are in need of eye care, we expect payment in full on receipt of your billing statement. The statement will reflect the amount you owe after your insurance has processed your claim. If no resolution can be made within 30 days, the account will be sent to the collection agency and dismissal from the practice may be initiated.

INSURANCE PAYMENTS SENT TO YOU
If insurance payments are sent to you, you are responsible for forwarding these payments to our office with a copy of the Explanation of Benefits received from your insurance company.

INSURANCE CHANGES
If you have had any changes in your coverage, please notify us. Even a small discrepancy can lead to a denial of payment.

CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE AND PAST DUE BALANCES
All co-payments are collected at the date of service. If, for any reason, the co-payment is not collected at the date of service, we will charge a fee of $11.50 to cover our cost of creating and sending an invoice to you.

Past due balances are due at the date of service unless previous arrangements have been made with an insurance counselor.

Insurance deductibles and fees for service not covered by your insurance policy are due at the time of service.

An example of a non-covered service is REFRACTION (unless you have a vision plan). REFRACTION is a procedure necessary for eye doctors to evaluate your vision and/or write glasses prescriptions. Unfortunately, many insurance companies, including Medicare, do not cover this procedure. Our fee for this service is $45, and is expected at the time of check-out. This fee is subject to change.

Our office accepts VISA, MasterCard, American Express, Discover, cash, money orders and checks. No post-dated checks will be accepted. Any bounced check will incur a $35 charge.

SELF PAY PATIENTS
You are responsible for your payment in full at the time of service.

FAILURE TO PAY
Patients who ignore collection notices or fail to pay their balances risk negative credit ratings and possible dismissal from the practice.

MISSED APPOINTMENTS
If you need to cancel an appointment, we ask at least 24 hours notice. This allows us to offer the appointment to another patient. If multiple appointments are missed without notice to us, you may be discharged from the practice.

We hope this clarifies any issues you may have about our office financial policies. Signing below verifies that you have read and understand this form and that you will abide by the policies stated. Please feel free to ask our insurance staff any questions about our policies.

Patient Name (please print)**:**_____ **Patient/ Custodian Signature:**_____ **Date:**_____