Garrett Eye Clinic

***COMPLETE** EYE CARE*

PATIENT REGISTRATION

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DATE OF BIRTH _____ SEX: M F SOCIAL SECURITY # _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

EMPLOYER NAME _____ EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

EMERGENCY NOTIFICATION

NAME _____ PHONE _____ RELATIONSHIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY# _____ GRP# _____

EFFECTIVE DATE _____

SECONDARY INSURANCE _____ POLICY# _____ GRP# _____

EFFECTIVE DATE _____

GUARANTOR INFORMATION

NAME _____ DOB _____ SS# _____

EMPLOYER NAME AND ADDRESS _____

CLINIC POLICY, CONSENT FOR TREATMENT AND INSURANCE FILING

I, the undersigned, authorize the providers of Garrett Eye Clinic and its designees to provide treatment and services and may use my health information for treatment, payment, and health care operations, which includes submitting information to Medicare, Medicaid and/or other third party payors for the purposes of processing insurance claims. I further authorize non-practice labs, radiology centers, pathologists, and radiologists who may interpret and/or report on diagnostic tests ordered by Garrett Eye Clinic to provide such treatment and use my health information for billing and payment purposes. I understand that I am responsible for payment of services rendered to me by Garrett Eye Clinic. For all children under eighteen (18) years of age, the parent or guardian requesting treatment assumes all financial responsibility. Payment is due at the time of service including any co-payment and deductibles.

If my account were to require the services of a collecion agency, I understand that I will be responsible for all fees related to the collection process including collection agency fees and attorney fees.

*Signature _____ Date _____

I, the undersigned, assign directly to Garrett Eye Clinic all medical benefits payable on my behalf for services rendered to me by Garrett Eye Clinic providers. i authorize Garrett Eye Clinic to release all information necessary to secure payment of benefits. I authorize the use of this signature for insurance billing purposes.

*Signature _____ Date _____

*LIFETIME SIGNATURE