EyeCare Associates of East Texas

WELCOME

REGISTRATION FORM

Please fill out completely. Insurance may not pay if we cannot provide all this infomation.
If a question is not applicable, please enter N/A.

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Mailing Address _____ City _____ State _____ Zip Code _____

Patient Numbers:

Home _____ Work _____ Cell _____

Social Security # _____ Date of Birth _____ Sex: Male / Female (circle one)

Marital Status: 1) Single _____ 2) Married _____ 3) Divorced _____ 4) Widowed _____ 5) Legally Separated _____

Race: 1) Asian _____ 2) Caucasian _____ 3) Hispanic _____ 4) Indian _____ 5) African American _____

Physician You Are Seeing Today: (Circle One)

Beall	Bochow	Frazier	Kiblinger	Mack
Pennell	Prater	Schreiber	Timmons	Wick

Referring Physician _____ Primary Care Physician _____

PERSON RESPONSIBLE FOR THE BILL ***(ONLY APPLICABLE IF OTHER THAN THE PATIENT)***

Last Name _____ First Name _____ M.I. _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____ Ext _____ Relationship to Patient _____

INSURANCE INFORMATION ***(PLEASE LIST POLICY HOLDER IF OTHER THAN PATIENT)***

Primary Insurance Company: _____ Policy # _____

Address _____ Group # _____

Policy Holder _____ Relationship to Patient _____ Effective Date _____

Date of Birth _____ Sex _____ Social Security # _____ Employer _____

Other Insurance Company: _____ Policy # _____

Address _____ Group # _____

Policy Holder _____ Relationship to Patient _____ Effective Date _____

Date of Birth _____ Sex _____ Social Security # _____ Employer _____

ADDITIONAL PATIENT INFORMATION E-Mail Address _____

Emergency Contact _____ Phone # _____ Relationship to Patient _____
(relative not living with you, neighbor or friend)

How Did You Hear About EyeCare Associates?

1) Friend/Family (Name) _____ 2) TV _____ 3) Radio _____ 4) Newspaper _____

5) Yellow Pages _____ 6) Website _____ 7) Doctor _____ Other _____

Student: Full Time _____ Part Time _____ D.L. # _____

Has anyone in your household been here before? ___ Yes ___ No Where do you work? _____

- OVER -

ECA Initials _____

EyeCare Associates of East Texas

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by EyeCare Associates of East Texas physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend EyeCare Associates of East Texas clinics, unless revoked by me in writing.

RELEASE OF INFORMATION: I understand my signature authorizes release of confidential medical information necessary to pay the claim to Medicare or other health insurer.

I understand that I may revoke this authorization for the release of information at any time, by providing written notice to EyeCare Associates of East Texas, except to the extent that action has been taken in reliance on it.

RELEASE OF LIABILITY: I release and agree to hold harmless EyeCare Associates of East Texas and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization.

I understand EyeCare Associates of East Texas cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services payable to me, payable to the providers of EyeCare Associates of East Texas. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payor, up to the total amount of my medical and health care charges, to the providers of EyeCare Associates of East Texas. I certify that the information I have provided in connection with any application for payment by third party payors, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by EyeCare Associates of East Texas.

REFRACTION: I understand that refraction (measurement of eyes for glasses / contacts) is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

Patient/Other Legally Authorized Person	Witness
Printed Name and Relationship to Patient	Date