

# NORTHWEST EYECARE PROFESSIONALS REGISTRATION FORM

(please print)

Today's date: \_\_\_\_\_

## A. PATIENT NAME AND REFERRAL INFORMATION

Patient's First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Other immediate family members seen here: \_\_\_\_\_

If you are a new patient, whom may we thank for referring you to us? \_\_\_\_\_

Insurance Plan: \_\_\_\_\_

Current Patient: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Yellow Pages

Other Webs \_\_\_\_\_

## B. BILLING/INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist. Complete this section ONLY if you are providing billing/insurance information for the first time or your billing/insurance information has changed.

Person responsible for bill: \_\_\_\_\_

Birth date: \_\_\_\_\_

/ /

Address (if different): \_\_\_\_\_

Home phone no. (if different): \_\_\_\_\_

( )

Is this person a patient here? \_\_\_\_\_

Yes

No

Employer: \_\_\_\_\_

Is this patient covered by VISION insurance? \_\_\_\_\_

Yes

No

Please indicate VISION insurance: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

Subscriber's S.S. no.: \_\_\_\_\_

Birth date: \_\_\_\_\_

/ /

Group no.: \_\_\_\_\_

Policy no.: \_\_\_\_\_

Co-payment: \_\_\_\_\_

\$

Patient's relationship to subscriber: \_\_\_\_\_

Self

Spouse

Child

Other

Name of MEDICAL insurance or Secondary VISION insurance (if applicable): \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

Group no.: \_\_\_\_\_

Policy no.: \_\_\_\_\_

Patient's relationship to subscriber: \_\_\_\_\_

Self

Spouse

Child

Other

## C. ACKNOWLEDGEMENT OF RESPONSIBILITY

The information provided on my insurance card and/or provided above is true to the best of my knowledge. When making a third party claim, I authorize Northwest EyeCare Professionals to bill the insurance company on my behalf for any covered charges. I authorize the release of any medical information necessary for processing the claim. I also authorize my insurance company to pay insurance benefits on my behalf to Northwest EyeCare Professionals directly. I understand and agree that regardless of my insurance benefits, I (or my guarantor) am responsible to pay the balance on my account for all professional services and materials provided.

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

## D. ACKNOWLEDGEMENT OF HIPPA PRIVACY PRACTICES

***I acknowledge that I have been given a copy of the Notice of Privacy Practices for Northwest EyeCare Professionals.***

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

***Patient was given this notice, but refused to sign it.***

\_\_\_\_\_  
*Staff Signature*

\_\_\_\_\_  
*Date*