Andersen Eye Associates, LLP

Welcome To Our Office

Patient Registration Form – Please Print

Date:

Patient Name (Last, First, Initial, Suffix)				
Address ❑ Home ❑ Business ❑ Temporary				
City	State	Zip Code	Home Phone	
Birth Date	Social Security No.	Sex ❑M ❑F	Marital Status ❑M ❑S ❑W ❑D	Drivers License No.
Family Doctor	Previous or Referring Doctor	Who is your Andersen Eye Doctor?		

Responsible Party for Insurance

Who is the Cardholder? ❑ Self ❑ Spouse ❑ Other

If charges are not covered by insurance, who is responsible for payment? ❑ Self ❑ Spouse ❑ Other

Last Name ❑ Check if same as Patient	First Name	Initial	Jr.,Sr.
Address	Birth Date		
City	State	Zip Code	Phone

Patient Employer Information

Employer	Occupation		
Address			
City	State	Zip Code	Phone

Who Should We Contact In An Emergency?

Last Name	First Name	Relationship	Phone

Authorization for Treatment of a Minor

I authorize the providers at Andersen Eye Associates to examine, diagnose, and treat the person listed below, for whom I am legally authorized to give consent. I authorize such services that the provider feels are necessary or advisable and are rendered under the provider's general or specific instructions.

Patient Name ______________________ Birth Date ____________

Parent/Legal Guardian Signature ______________________ Date ____________

Parent/Legal Guardian Name *(Print)* ______________________

Relationship to Patient ______________________

Witness Signature ______________________ Date ____________

Andersen Eye Associates, LLP

______________________________ ______________________________
Beneficiary's Name (Print) **Medicare ID #**

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Andersen Eye Associates for services furnished me by Andersen Eye Associates. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Andersen Eye Associates accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP INSURANCE:** If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Andersen Eye Associates.

3. **OTHER INSURANCE:** I hereby authorize payment of my medical and surgical insurance benefits to Andersen Eye Associates. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Andersen Eye Associates. I authorize Andersen Eye Associates to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

4. **NON-COVERED SERVICES:** I understand that Andersen Eye Associates' contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services that are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Andersen Eye Associates to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Andersen Eye Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Andersen Eye Associates for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance, insuring the patient or any other party liable to the patient is hereby assigned to Andersen Eye Associates. I agree to pay co-payments and/or deductibles that are designated by my insurance company or health plan. I agree to pay them to Andersen Eye Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

6. **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received Notice of Privacy Practices issued by Andersen Eye Associates that was effective April 14, 2003.

X ______________________________ ______________
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

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