



# EYECARE REGISTRATION AND HISTORY

Patient Acct # \_\_\_\_\_

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS # \_\_\_\_\_

Patient Name \_\_\_\_\_

Last

First

MI

Preferred Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

Sex \_\_\_M\_\_\_F Age \_\_\_\_\_ Birth date \_\_\_\_\_

Occupation \_\_\_\_\_

Patient Employer \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Whom may we thank for referring you?

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_Family \_\_\_Friend \_\_\_Phone Book \_\_\_Radio \_\_\_TV \_\_\_Other

## 2 ACKNOWLEDGEMENT OF RECEIPT

1. I acknowledge that I received a copy of Drs. Pohl, Dobbins & Letourneau's Notice of Privacy Practices dated April 14, 2003.
2. I also have read the attached Financial Policy.

### Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy.

### ***Regarding Insurance:***

We will be happy to file your insurance for all services provided by Drs. Pohl, Dobbins & Letourneau; however, your insurance is a contract between you and your insurance company. It is your responsibility to know and tell us if there is a vision rider (i.e. VSP or Superior) with your insurance policy. Please be aware that some and perhaps all of the services provided may be non-covered services. We cannot guarantee payment from your insurance company. It is your responsibility to pay the balance for services as determined by your benefit plan.

### ***Credit Cards:***

We accept Visa, MasterCard and Discover credit cards.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Patient or Personal Representative:

Description of the Personal Representative's authority to act on behalf of the patient: \_\_\_\_\_

## 3 MEDICARE AUTHORIZATION

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, or item, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Medicare is likely to deny payment for a portion of what you are ordering.

My supplier has notified me that he or she believes that, in my case, Medicare is likely to deny payment for the items or services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date