THE COLORADO RETINA CENTER PATIENT REGISTRATION FORM

Dr. Mr. Mrs. Miss Ms ____ Date______________

Address:____City______________________________

State______ Zip___________ Home Phone# _______________ Cell Phone#__________________

Sex: M F Martial Status: Single Divorced Married Widowed Ethnic Origin:________________

Social Security #______-____-_______ Date of Birth: _______/______/______

Patient's Spouse/Parent/Guardian:____

Patient's Employer:_____________________________________ Work Phone #___________________

Occupation:_______________________________________ Retired:____________________

Emergency Contact: Name_________________________________ Phone #______________________

Referred by: Name_______________________________________ Phone # _____________________

Family Physician: ____ Phone#______________________

Date of onset of symptoms/accident:____

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PLEASE WRITE YOUR NAME AS IT APPEARS ON YOUR INSURANCE CARD

INSURANCE: PLEASE LIST THE SUBSCRIBER OF THE POLICY IF OTHER THAN THE PATIENT

PRIMARY: ____

Policy#________________________ Group: _________________________

Subscriber: ____

SECONDARY: ____

Policy#________________________ Group___________________________

Subscriber: ____

I authorize the release of any medical information necessary to process all claims.

Patient's Signature: ____ Date: ________________

I authorize the release of payment for medical benefits to my physician.

Patient's Signature: ____ Date: ________________

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FOR MEDICARE PATIENTS ONLY

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Name of beneficiary

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Health Insurance Claim Number

I REQUESTS THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY OR IN THE COLORADO RETINA CENTER, INCLUDING PHYSICIAN SERVICES. I RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS OR BENEFITS FOR RELATED SERVICES.

Patient's Signature: ____ Date: _________________

COLORADO RETINA CENTER FINANCIAL POLICY

PLEASE READ THIS SUMMARY OF OUR FINANCIAL POLICY. IF YOU HAVE ANY QUESTIONS ABOUT FEES, INSURANCE COVERAGE OR PROCEDURES, OR NEED TO TELL US ABOUT ANY SPECIAL CIRCUMSTANCES, OUR STAFF IS ALWAYS READY TO DISCUSS THESE WITH YOU.

1. All patients (or their parents or legal guardian, in the case of children) are personally responsible for fees which they incur, regardless of any insurance coverage which may apply.

2. **FEES AND CO-PAYS ARE DUE AND PAYABLE AT THE TIME SERVICES ARE PROVIDED.**

   Normally, the full amount is expected. In certain cases, a portion of the charges may be paid over an extended period, according to a previously agreed upon schedule arrangement.

3. When arrangements have been made for an extended payment schedule, a late fee and/or interest may be_added to delinquent payments. If an account becomes seriously delinquent, the full amount_may become due and payable at once. Unpaid accounts will be assigned to a collection agency. All collection fees, attorney's fees and court costs will be added to the delinquent_accounts, if this become necessary.

4. Our contracts with insurance companies differ. In some cases (usually HMO-type policies),_we will submit the paperwork; in others, this must be done by the patients. We will provide a statement of charges and payments at each visit to aid patients who must submit claims to their insurance companies.

5. Payment may be in the form of cash, personal checks, Money orders, Master Card or Visa. We will add a charge of **$35.00** for returned checks, plus any fees any banking fees that we incur from our bank.

Patient's Signature: ______________________________ Date: __________