OPHTHALMOLOGY NJ, LLC

Patient Registration Form

Mr. Mrs. Miss Ms. : _____ Date: _____
Last First M.I.

Social Security Number: _____-_____-_____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Cell Phone: _____-_____-_____ Email Address: _____

Referred By: _____

❑ Physician ❑ Relative ❑ Patient ❑ Yellow Pages ❑ Newspaper

Patient's Employer: _____ Work Phone: _____-_____-_____
Patient's Occupation: _____

Party Responsible for Fees: ❑ Self
Other than Self-Name: _____ Relation:_____
Address: _____ City: _____ State:_____ Zip: _____
Home Phone: _____-_____-_____

INSURANCE INFORMATION

❑ **Primary Insurance:** Insurance Co: _____ Policy #:_____

Insured's Name: _____ Insured's D.O.B.: ____/ ____/____

Insured's SSN: _____/____/_____ Relationship to Patient: _____

❑ **Secondary Insurance:** Insurance Co: _____ Policy #:_____

Insured's Name: _____ Insured's D.O.B.: ____/ ____/____

Insured's SSN: _____/____/_____ Relationship to Patient: _____

Whom to notify in an emergency (nearest Relative):
Name: _____ Relationship: _____

Address: _____ City: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

OPHTHALMOLOGY NJ, LLC

Financial Agreement, Assignment and Signature on File

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substituted for payment, Some companies pay fixed allowances for certain procedures, and others pay a certain percentage of the charge. In order to control billing costs, we request that any co-payments, deductible amounts or uncovered fee for services be paid at the time services are rendered.

Patient Signature:_____ Date: _____

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Ophthalmology NJ, LLC for services furnishes to me by aforementioned practice. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine payments be made and authorizes the release of medical information to pay the claim. Ophthalmology NJ, LLC accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for **YEARLY DEDUCTIBLE, COINSURANCE, REFRACTIONS AND ANY NON-COVERED SERVICES**. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Patient Signature:_____ Date: _____

MEDIGAP OR SECONDARY INSURANCE COVERAGE

If a Medigap policy or other health insurance policy is indicated in Item 9 of the HCFA1500 Form or elsewhere on the other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that the payment of the authorized secondary insurance benefits be made on my behalf to Ophthalmology NJ, LLC.

Patient Signature:_____ Date: _____

OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to Ophthalmology NJ, LLC for services rendered. I understand that I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Ophthalmology NJ, LLC. I authorize Ophthalmology NJ, LLC to release any information required to process any and all claims for reimbursement on my behalf.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is the be considered as valid as an original. I hereby authorize said insurance assignee to release all information necessary to secure the payment.

Patient Signature:_____ Date: _____