Patient Registration Form

Patient Information:

Last Name: _____ First Name: _____ M.I.: ____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Gender: M / F

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

Home Number: _____ Work Number: _____

Cell Number: _____ Email Address: _____

Policyholders Information:

Last Name: _____ First Name: _____ M.I.: ____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Gender: M / F

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

Home Number: _____ Work Number: _____

Cell Number: _____ Relationship to Patient: _____

IF THE PATIENT IS UNDER THE AGE OF 18, the adult who completes and signs this paperwork is the *RESPONSIBLE PARTY*. No matter if you are related to patient or not. We may request a copy of your photo i.d.

Responsible Party Information:

Last Name: _____ First Name: _____ M.I.: ___

Mailing Address: _____

City: _____ State: _____ Zip: _____ Gender: M / F

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

Home Number: _____ Work Number: _____

Cell Number: _____ Relationship to Patient: _____

May we communicate via text message about appointment reminders and arrival of materials? Y / N

Filing Insurance Claims

As a courtesy to our patients, we file charges to most insurance companies, so that you do not have to. In order for us to accomplish this successfully *we must obtain correct information and all information* at check in. In the event we are provided incorrect information the claim will be rejected by your insurance carrier. Rather than going through the time and expense of determining the correct information, we will bill you, leaving you to file your claim with your insurance company.

Please initial the following:

_____I've provided the requested demographic information as is appears with my insurance plan.

_____I understand that if I've provided incorrect information and my claim is rejected then I will be billed by Gordy EyeCare

_____I understand that if my claim is rejected due to my failure to provide correct and updated demographic information then I will be responsible for my OWN filing with my insurance carrier.

_____If I am an existing patient, I've made the staff at Gordy EyeCare aware of any changes to my insurance information.

_____I understand that it is my responsibility to know my insurance benefits at the time of service.

_____I understand it is my responsibility to have any and all referrals for needed appointments by my insurance carrier's discretion.

_____I understand that all payments are expected at the time of service. We will not bill you for any money calculated at your appointment. If unable to provide payment, please reschedule for a more convenient time.

_____I understand that if I receive a bill after insurance has made their determination, that I will receive a 1st, 2nd, and final statement before going to PROFESSIONAL COLLECTIONS.

_____I understand there is a $30 return check fee and a $9 bank fee on any check returned. I understand that all check writing privileges will be suspended. If this is left as an unpaid balance, my check will be turned over to the LEE COUNTY WORTHLESS CHECK UNIT.

Today's Date: _____ (new paperwork will be updated a year from today)

Print Patients Name: _____

Print Responsible Party Name: _____

Responsible Party Signature: _____

Explanation of contact lens evaluation/fitting.

If you are not currently wearing contacts or your prescription has expired and you are interested in wearing them, the doctor will have to do a separate evaluation/fitting that is not part of the comprehensive eye exam. There are different levels of contact lens evaluations/fittings. The prices are based off of the set amount that your individual vision insurance company charges. If you are a self-pay patient the price is based off of the complexity of your prescription ranging from $60.00 to $125.00. Please ask a technician for an explanation about the charges if you have any additional questions.

If you agree to a contact lens evaluation/fitting, you will be given a trial pair of contacts and a two week follow up. You will have to be wearing the contacts when you come back for your two weeks follow up before a prescription can be finalized.

We offer *routine* contact lens checks at no charge for three months from original evaluation/fitting date.

Contact lens evaluations/fittings are non-refundable!

PLEASE CHECK BELOW

_____Yes – I would like a contact lens evaluation/fitting today. I understand that payment will be due at this time. Contacts are considered a medical device and have to be renewed yearly.

_____No – I do not want a contact lens evaluation/fitting today. I understand that I will not be able to purchase contacts without a current prescription.

Restocking Fees

I understand that eyeglasses and contact lenses are custom made to fit each patient's wants and needs.

Glasses: If you purchase glasses and are unsatisfied Gordy EyeCare will be more than happy to do one re-make at no charge. However, if you private paid for glasses and would like a refund there will be a 30% restocking fee. If you used your vision insurance it will be to the discretion of each insurance company.

Contacts: If you purchase contacts and are unsatisfied Gordy EyeCare will be more than happy to refund at a 30% restocking fee. If you used your vision insurance it will be to the discretion of each insurance company.

Please initial: _____

Explanation of refraction

A refraction is necessary to determine the performance of the visual system and is the first step in evaluating the health of the eye. Although a refraction is also used to determine the need for corrective eyeglasses and/or contact lenses, this practice performs refractions as an essential part of the medical eye examination. A refraction is also necessary to evaluate a patient for surgery and some eye conditions. **Unfortunately, most medical insurance plans DO NOT cover the cost of the refraction. In these cases, the patient will be responsible for the refraction charge of $25 on the day of appointment.**

ACKNOWLEDGEMENT RECEIPT

By placing a check below, I acknowledge I have been offered a copy of the Gordy EyeCare's Notice of Privacy Practices.

( ) Yes, I would like to receive a copy of Gordy EyeCare's Notice of Privacy Practices.

( ) No, I do not wish to receive a copy of Gordy EyeCare's Notice of Privacy Practices.

Todays Date: _____ (new paperwork will be updated a year from today)

Print Patients Name: _____

Print Responsible Party Name: _____

Responsible Party Signature: _____