SoCal eye You Won't Believe Your Eyes™

Registration Form

Patient Information

First Name:_____ Last:_____

Birthdate:_____ Age:_____ Sex: ☐ M ☐ F Social Security:_____

Address:_____ City:_____ State:_____ Zip:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Contact Information

Home Phone:_____ Cell:_____ Work:_____

Email:_____ **In Case of Emergency Contact:** Name:_____

Relationship:_____ Phone:_____

Insured Party Information (if different than above)

Name:_____ Relationship to Patient_____

Birthdate:_____ Sex: ☐ M ☐ F Social Security:_____

Insurance Name:_____ ID#_____

Secondary Insurance Name:_____ ID#_____

Additional Information

Do you have an Optometrist? ☐ Yes ☐ No Name:_____

Do you have a Primary Care Physician? ☐ Yes ☐ No Name:_____

How did you hear about SoCal Eye?

☐ Family/Friend ☐ Primary Care Physician (PCP) ☐ Website ☐ Insurance Plan ☐ Optometrist (O.D.)

Do you have a Pharmacy? ☐ Yes ☐ No Name:_____

Address:_____ City:_____ Phone:_____

_____ _____

Signature of Insured or Responsible Party Date

Financial Policy

HMO/PPO Coverage

If you have insurance that we are contracted with, we will require a copy of your insurance card, the mailing address for your insurance company, and **payment of any coinsurance and deductibles are due at the time of service**.

Medicare

We participate in the Federal Medicare program. Medicare will pay 80% of the approved charges after you pay your annual deductible. As the patient, you will be responsible for your 20% coinsurance unless you have a secondary plan.

Full Vision Refractions/Prescription for Glasses- $50

Refractions are a **non-covered** service under the MEDICARE program. Medicare does differentiate between a "medical refraction" and refractions performed solely for the purpose of providing glasses.

OTHER INSURANCE plans may vary depending on your individual benefit coverage. In our experience, unless you have vision benefit coverage on your insurance, it will probably **not** cover the cost of the **refraction**. If your insurance does NOT cover the refraction then there will be a $50 charge for the service which will be collected the day of visit.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that in the event a credit/debit card or check payment is returned, the account will be assessed a $35 service fee. Further, if patient balance is not paid within 90 days of date of service, a $35 collection service fee may be assessed.

I hereby authorize the doctor to release all information necessary to my insurance company to secure the payment of benefits.

_____ _____

Signature of Insured or Responsible Party **Date**

HIPAA Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of **Southern California Eye Physicians and Associates** Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Signature of Insured or Responsible Party **Date**