

Envision Eye & Laser Center
Advanced Eye Care Medical Center, PA
Registration Sheet

Date ___/___/___

(Please Print Clearly)

Patient's Full Name _____ Social Security # _____

Date of Birth ___/___/___ Age _____ Marital Status: S M D W Gender M or F

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Which number is best to call home /work /cell? _____ May a private voice message be left for you YES/ NO

How late in the evening can phone calls be returned? _____ May we contact you at work? Yes or No

May we contact you via email? Yes or No E-mail: _____

Patient's Employer _____ Employer Phone # _____

Address _____ City _____ State _____ Zip _____

Spouse/Partner's Name _____ Date of Birth ___/___/___

Spouse/Partner's Employer _____ Work # () _____

Address _____ City _____ State _____ Zip _____

Emergency Contact (Other than Spouse/Partner) _____ Phone # () _____

Financial Information

Financially Responsible Person _____ Relationship _____

Address (if different) _____ City _____ State _____ Zip _____

Are you covered under Medicare? Y or N Medicare # _____

Primary Health Insurance Company Co-Pay \$ _____ Secondary Health Insurance Company

Identification # _____

Identification # _____

Group # _____

Group # _____

Subscriber _____

Subscriber _____

Subscriber's Date of Birth ___/___/___

Subscriber's Date of Birth ___/___/___

Subscriber's Social Security # _____

Subscriber's Social Security # _____

Effective Date _____

Effective Date _____

Referred By _____ Phone Number _____

Address _____

Primary Care Physician _____ Phone Number _____

Address _____

CANCELLATION AND "NO SHOW" POLICY: Patients are expected to cancel within 24 hours of scheduled appointments. If you cancel an appointment the same day or fail to come "NO SHOW" to a scheduled appointment, you may be charged twenty five (\$25.00) dollars.

_____ (Please initial you have read and understood this policy)

FINANCIAL POLICY: I certify that the information I have reported is correct. I acknowledge that it is the policy of this office that I am responsible for obtaining pre-approval (precertification) from my health insurance carrier if that is needed, to find out what my related benefits are with my health insurance carrier, to know if I have a co-pay, deductible, co-insurance or any other fees I might have to pay Envision Eye & Laser Center/Advanced Eye Care Medical Center PA.

I understand that I am financially responsible for any non-covered services provided or allowed by law.

I hereby assign and transfer to Dr. Renee Bovelle, Envision Eye and Laser Center/Advanced Eye Care Medical Center, PA my health insurance payment benefits. I authorize the release of any medical information needed to determine benefit payments.

In addition, I agree that in the event of my non-payment for services provided, to bear the cost of collection, and/or court costs and reasonable attorney fees should this be required. I understand that if I do not pay my bill promptly Dr. Bovelle is willing to work me with to arrange for a payment plan. If I do not make such arrangements, I understand that my outstanding balances may accrue 1.5% interest per month after 30 days and my account will be sent to a collections agency.

_____ (Please initial you have read and understood these policies)

CONFIDENTIALITY: As your eye care specialist, it may be necessary to communicate in writing, by phone, fax or electronic transmission to your primary care physician, or other health care providers, health insurance companies, Medicare/Medicaid or health claims clearinghouses. Communication between your health care professionals is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information that you have agreed to be released as a participating member.

Envision Eye & Laser Center's practice will make its best efforts to protect your privacy. This includes nondisclosure of your personal health information for marketing and fundraising purposes. I understand and agree that my personal health information may be transmitted electronically to consulting health care practitioners to facilitate my medical care.

I acknowledge that I have had an opportunity to read the office's Notice of Privacy Practices and Health Care Disclosure Information that contains a description of the uses and disclosures of my personal health information. I understand that this information may be updated and I will be able to see the new information. The policy of this office is to strive to be in compliance with federal and state medical practice guidelines.

_____ (Please initial you have read and understood these policies)

Patient's name _____ (Please print) Date _____

Signature of Patient _____

Signature of parent of minor child _____

Signature of Financially Responsible Person _____

_____ Print Name and Relationship to Client

A copy of this can be considered as valid as the original.