PATIENT REGISTRATION FORM

Date: _____

DOMINION EYE CARE

First Name	MI	Last Name		Sex □M □F
Address		City	State	Zip Code
Home Phone	Work Phone	Cell Phone	Preferred Phone	
Date of Birth / Age	Social Security #	Marital Status S □ M□ D□ W□	E-mail Address	
Race □ decline	Ethnic Group □ decline	Primary Language Spoken		
City of Birth	State	Zip code	Country of Birth	
Employer	Occupation	Industry		
Financial Responsible person □ Patient □ Spouse □ Parent □ Employer	Name of responsible person	Phone Number		
Address of Financial Responsible person	State	Zip Code		
Is patient residing in a nursing facility? □ Yes □ No	If yes, name and address of facility	Phone Number		
Emergency Contact	Relationship	Phone Number		

Primary Care Doctor

Name: _____ **Phone Number:** _____

How did you hear about us? □ Friend □ Doctor □ Internet □ Other_____

INSURANCE INFORMATION

Primary Insurance

Insurance:_____ ID #_____

Policyholder: _____ **Policyholder SSN:** _____ **DOB:** _____

Secondary Insurance

Insurance:_____ ID #_____

Policyholder: _____ **Policyholder SSN:** _____ **DOB:** _____

COMPLETE BACKSIDE

FINANCIAL POLICY STATEMENT

Welcome to Dominion Eye Care, P.C. We are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. We ask that you carefully read and sign the following policy. We must emphasize, as your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company if we are participating providers. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. Worker's Compensation claims will be filed if all information is provided at the time of service. Payment must be received within 45 days or it becomes the patient's responsibility. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibility. This includes obtaining any referrals and/or authorizations, which your insurance company requires before care is provided. All copays, co-insurance and contractual obligation with your insurance company, you are responsible for 100% of the payments at the time services are rendered. Should a monthly payment plan become necessary, arrangements can be made through our office. Failure to pay for services or adhere to a payment plan will result in collection action. All collection costs incurred by Dominion Eye Care, P.C., including attorney's fees, will become the sole responsibility of the financial responsible party named herein. In consideration of the services performed by Dominion Eye Care, P.C. you agree to abide by the terms of this Financial Statement.

Patient/ Guardian Signature_____**Date:**_____

PATIENT'S AUTHORIZATION

I, _____ hereby authorize Dominion Eye Care, P.C. to apply for benefits on my behalf for services rendered. I request payment from _____ be made directly to Dominion Eye Care, P.C. ***(name of your insurance company)***

I certify the information I have provided on the front of this form is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the above-named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in the place of the original. I may revoke this authorization at anytime in writing.

Patient/ Guardian Signature_____ **Date:**_____