Adult Registration Form

PATIENT INFORMATION:

Patient Name: _____ M / F

Last | First | MI | Gender | Date of Birth

Street | Apt # | City | State | Zip | xxx - xx - _____ SSN (for ins. purposes)

Home phone # | Office Phone # | Cell Phone # | Email Address

Spouse's Name: _____ xxx - xx - _____

DOB (for insurance purposes) | SSN (for ins. purposes)

Home phone # (if different) | Office Phone # | Cell Phone # | Email Address

Referring Doctor | Clinic Name | Primary Care Doctor | Clinic Name

Other family members seen in this office

INSURANCE INFORMATION:

Primary Insurance: _____

Insurance Co. Name | Subscriber Name | Date of Birth

Insurance Address | ID # | Group #

Secondary Insurance: _____

Insurance Co. Name | Subscriber Name | Date of Birth

Insurance Address | ID # | Group #

I hereby authorize Northwest Pediatric Eye Care to release any medical or other information necessary in order to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any non-covered charges and any charges incurred by a collection agency in collecting any unpaid balances, and ***it is ultimately my responsibility to know the full extent of my insurance coverage*** . I understand a late-payment fee may be applied if I do not begin payment on an outstanding balance within 30 days of receiving my billing statement. I understand there is a $45.00 fee for missing scheduled appointments without at least 24 hours advanced notice.

CO-PAYMENT IS DUE AT THE TIME OF SERVICE

_____ _____

Printed name of responsible party | Signature of responsible party | Date

Acknowledgement of Receipt of Privacy Practices

By my signature below, I acknowledge that I have received a notice of the privacy practices of Northwest Pediatric Eye Care.

_____ _____

Printed name of responsible party | Signature of responsible party | Date

NWPEC 9/25/2005, Revised 12/2007, 3/11, 8/2013, 11/2013, 10/2014 3/2015