

# OPHTHALMOLOGY NJ, LLC

## Patient Registration Form

Mr. Mrs. Miss Ms. : \_\_\_\_\_ Date: \_\_\_\_\_

Last First M.I.

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

☐ Physician ☐ Relative ☐ Patient ☐ Yellow Pages ☐ Newspaper

Patient's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_

**Party Responsible for Fees:** ☐ Self

Other than Self-Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## INSURANCE INFORMATION

☐ **Primary Insurance:** Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's SSN: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to Patient: \_\_\_\_\_

☐ **Secondary Insurance:** Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's SSN: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Whom to notify in an emergency (nearest Relative):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

# OPHTHALMOLOGY NJ, LLC

## Financial Agreement, Assignment and Signature on File

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substituted for payment, Some companies pay fixed allowances for certain procedures, and others pay a certain percentage of the charge. In order to control billing costs, we request that any co-payments, deductible amounts or uncovered fee for services be paid at the time services are rendered.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Ophthalmology NJ, LLC for services furnishes to me by aforementioned practice. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine payments be made and authorizes the release of medical information to pay the claim. Ophthalmology NJ, LLC accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for **YEARLY DEDUCTIBLE, COINSURANCE, REFRACTIONS AND ANY NON-COVERED SERVICES**. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### MEDIGAP OR SECONDARY INSURANCE COVERAGE

If a Medigap policy or other health insurance policy is indicated in Item 9 of the HCFA1500 Form or elsewhere on the other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that the payment of the authorized secondary insurance benefits be made on my behalf to Ophthalmology NJ, LLC.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to Ophthalmology NJ, LLC for services rendered. I understand that I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Ophthalmology NJ, LLC. I authorize Ophthalmology NJ, LLC to release any information required to process any and all claims for reimbursement on my behalf.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is the be considered as valid as an original. I hereby authorize said insurance assignee to release all information necessary to secure the payment.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_