

PATIENT REGISTRATION

Mr. Mrs. Ms. Dr. _____
(Circle) First Name Initial Last Name

Address _____
Street City State Zip

Telephone # _____ Mobile # _____

Work Telephone # _____ E-mail _____

Date of Birth _____ Sex: Male _____ Female _____ Social Security # _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Guarantor (Person Financially Responsible) _____

*Guarantor Address _____ Phone # _____

*Guarantor Social Security # _____ Date of Birth _____

Primary Care Physician _____

Address _____

Referred By _____

Patient Employer/School _____ Phone # _____

Employer Address _____

Spouse/Guarantor Employer _____

Employer Address _____

Emergency Contact _____ Phone # _____

Nearest Relative Not Living with You _____ Phone # _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the notice of privacy practices of Center for Sight:

Patient/Guarantor Signature: _____ Date: _____

Waiver of Insurance Liability

Insurance Company _____

Insurance Member Name (if different than patient) _____

Member SS# _____ Date of Birth _____

Member Address _____

I acknowledge that the insurance information I have provided is the insurance for which I am currently eligible. I understand that I may be responsible for payment in full for all visits/procedures if not covered by insurance or if this information is incorrect.

I authorize Center for Sight to furnish information concerning my illness or medical treatment to the insurance carrier listed below, and hereby assign to the provider all insurance payments for medical services rendered to myself. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility.

I understand that there will be a \$25.00 handling fee assessed for any and all checks returned due to non-sufficient funds or account closure. In the event a collection agency is required to obtain funds, I will be responsible for all collection fees up to and including attorney costs.

Patient/Guarantor Signature: _____ Date: _____

Refraction Service and Fee

Refraction is the process of determining if there is a need for corrective eyeglasses or contacts lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover routine Refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for a Refraction is \$40, which will be the responsibility of the patient if your medical insurance does not cover the service.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement: I have read the above information and understand that the Refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand that any co-payment, coinsurance, or deductible I may have is separate from and not included in the Refraction fee.

Patient Signature (Parent for minor)

Date

A Statement to Center for Sight Patients

Regarding Dilation of Your Eyes

We would like to inform our patients that it may be necessary during the course of your exam to dilate your eyes with drops. In some people, the dilating drops cause blurred vision, light sensitivity, and inability to read. These problems go away as the effects of the drops wear off. This usually lasts 4-6 hours. You should be careful walking, going up and down stairs, and should not drive a car. In very rare cases, the drops may cause elevated eye pressure requiring further treatment.

It is for this reason that we recommend someone come with you as a driver at the time of your exam. Also, for your comfort, you may obtain dark glasses at the reception desk.

I certify that I have read and understand the statement regarding dilation and wish to proceed with the eye examination.

Signature of Patient/
Parent or Guardian: _____

Date: _____

Physician's Disclosure of Financial Interest

Name: _____

Date: _____

While you are a patient, you, or the named patient for whom you are a legal representative, may be referred to one of the health care entities listed below in which the physicians have a financial interest. In each case, you may choose to be referred to another health care entity if you so desire.

Dr. Pesavento

Dr. Behforouz

Indiana Surgery Center South

Beltway Surgery Center

Patient Acknowledgment

I, the above named patient, or legal representative of such patient, hereby acknowledge receipt of, on the date indicated above, a copy of the foregoing Physician's Disclosure of Financial Interest.

Signature: _____

Printed: _____