SEDGEWICK EYE ASSOCIATES, PATIENT REGISTRATION

Patient Name (last) _____ (first) _____ (DOB) _____ (Date) _____

(Address) _____ (city) _____ (state) _____ (zip) _____ (M / F)

(Home phone) _____ (Work Phone) _____ (SSN) _____

(Drivers License # and State)

Financial Information

Name of Primary Policy Holder (last) _____ (first) _____

(Address) _____ (city) _____ (state) _____ (zip) _____

(home phone) _____ (work phone) _____ (SSN) _____

(Employer) _____ (Employer's city/ state) _____

Primary Insurance Co. _____ **ID#** _____ **Group#** _____

(address) _____ (phone) _____

Secondary Insurance Co. _____ **ID#** _____ **Group#** _____

(address) _____ (phone) _____

I agree that I have been offered access to SEA's, **Notice of Privacy Practices** (HIPAA) policies. Written copies are available at my request for a nominal cost. I authorize Sedgewick Eye Associates, P.C. to discuss my medical information with the **following people/ with their relationship to me:**

_____

Assignment Authorization/ Release of Information

I, the undersigned, hereby authorize Sedgewick Eye Associates, P.C., (SEA) its Doctors and/or its agents to apply for benefits on my behalf for services rendered to me or my dependents. I request payment from my insurance carrier be made directly to SEA. I certify that the above information is correct and further authorize the release of any information for any claim to my insurance carrier. I agree that a fax copy of this release and of my medical records may be used in lieu of the original and authorize its release to all parties involved in my care.

Guarantee of Payment/ Non-Covered charges

I, the undersigned, understand and agree that I am financially responsible for all charges including those not covered by my health insurance and/ or Medicare. Payment is due at the time of services rendered. I agree that it is a matter between me and my insurance company whether or not the insurance company pays SEA, all,a portion, or none of my medical bill. I further understand that **Medicare** and/ or my health insurance company **may not cover** all services rendered, such as **refractions, routine eye exams, eye glasses and other ancillary testing.** Charges for these services may be obtained prior to the examination. I understand that if services are denied by Medicare and/ or my insurance company, then it will be **my responsibility** to pay for these charges. **Regardless of your insurance situation, I understand that I am responsible for any balance due.** SEA will resubmit your claim once. After the first appeal, you will be responsible for all charges and for any future appeals.

In the event that the account must be placed with an attorney or a collection agency, I agree to pay all of the attorney fees, all of the collection costs and interest on the unpaid balance of 18% per annum.

You must give at least 48 hours notice of appointment cancellation. If not, a $35 fee will be charged

Signature of Responsible Party: _____ **Date** _____

Witness: _____ **Date** _____