CEDAR CREEK EYECARE
DOCTORS OF OPTOMETRY

WELCOME TO OUR OFFICE
PATIENT REGISTRATION

Date:_____

Name:_____ Birth Date:_____
Age:_____ Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐ Other ☐ SS#_____
Address:_____
City:_____ State:_____ Zip:_____
E-Mail:_____
Home#:_____Cell#_____ Text: Yes☐ No☐
Employer:_____ Occupation:_____
Work #: _____

Parent/Guardian_____ Phone #_____

Are you interested in receiving information regarding laser surgery? ☐ Yes ☐ No

How did you hear about our office? Website / Phone Book / Insurance / Referral _____

Insured's Information

Insured's Name:_____ Insured's DOB_____
Insured's Employer_____ Insured's SS#_____
Relationship to Insured_____ Insured's Phone #_____
Insured's address_____
City_____ State_____ Zip_____

Additional Patient Information

Family Physician name & phone #:_____

Last Medical Exam:_____ Last Eye Exam:_____

Preferred Language_____ Race_____ Ethnicity_____

Weight_____ Height_____

AUTHORIZATION

(Lifetime Authorization)

I certify that I have provided and answered all questions to the best of my knowledge and that providing incorrect information can be dangerous to my health. I authorize Cedar Creek EyeCare to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Tufts' benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further agree that any costs and/or attorney fees expended to enforce payment of my unpaid balance will be my responsibility.

HIPAA Acknowledgement

I acknowledge that I have been offered/received a copy of Cedar Creek EyeCare, Doctors of Optometry Notice of Privacy Practices. Initials_____

INSURANCE AND BILLLING POLICY

Our staff makes every effort to obtain any necessary insurance information and or authorizations from the appropriate insurance company prior to your exam date. Please remember that any information provided to us by your insurance company is **not** a guarantee of payment but rather, a summary of your benefits as of the date of the phone call. We will automatically bill your insurance company provided we have all the necessary information. It is our policy to contact the insurance company prior to billing a patient in the event the insurance company has not paid according to the summary of benefits provided. If we are unable to resolve the matter directly with the insurance company the patient will be billed the remaining balance after any necessary insurance adjustments are made. At that time you are responsible for your bill regardless of the status of your insurance. We make every effort to be accurate in our filings and our billings. Please do not hesitate to contact us if you have any questions regarding a statement.

_____ _____

Signature (Patient/Parent/Guardian) Date