

# Matossian Eye Associates

## REGISTRATION INFORMATION

Welcome to our office!

### Patient Information

Please print

Date \_\_\_\_\_

Name \_\_\_\_\_ Telephone# (Home) \_\_\_\_\_  
last first middle

Street address \_\_\_\_\_ Apt # \_\_\_\_\_ Telephone# (Work) \_\_\_\_\_ ext \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone# (Cell) \_\_\_\_\_

Sex M  F  Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Single  Married  Other  E-mail \_\_\_\_\_

I would like to be referred to as (ex: Mrs. Smith, John or your nickname) \_\_\_\_\_

Occupation \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_

Business address \_\_\_\_\_

Name of spouse or Guardian \_\_\_\_\_ Occupation \_\_\_\_\_

In case of an emergency, contact \_\_\_\_\_ Telephone# \_\_\_\_\_

Name of nearest relative (not living with you) \_\_\_\_\_ Telephone# \_\_\_\_\_

Name of your pharmacy \_\_\_\_\_ Telephone# \_\_\_\_\_

How did you hear about **Matossian Eye Associates**? (VERY IMPORTANT – WE WANT TO PROVIDE FEEDBACK)

Physician (name) \_\_\_\_\_  Individual (name) \_\_\_\_\_

Hospital (name) \_\_\_\_\_  Insurance Company  Phone Book  Internet  Other \_\_\_\_\_

Do you have another Eye Doctor?  Yes  No Did they ask you to come see us?  Yes  No

Eye Doctor's Name and Address \_\_\_\_\_

### HEALTH INSURANCE COVERAGE

PLEASE INCLUDE ANY LETTERS WITH ID#. COPY OF INSURANCE CARD NEEDED

**PRIMARY CARRIER** \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber:  Self  Spouse  Parent Subscriber Date of Birth \_\_\_\_\_

**SECONDARY CARRIER** \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber:  Self  Spouse  Parent Subscriber Date of Birth \_\_\_\_\_

**IF THE NAME OF THE INSURANCE POLICYHOLDER IS OTHER THAN THE PATIENT, PLEASE COMPLETE**

Name of Policyholder \_\_\_\_\_ Address of Policyholder \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone# (Policyholder) \_\_\_\_\_

SS# of Policyholder \_\_\_\_\_ Date of birth \_\_\_\_\_

Employer of Policyholder \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

OVER 

# FINANCIAL POLICY

**METHOD OF PAYMENT:** You can choose to pay by cash, check, credit card, or money order.

**PAYMENT:** All charges are due at the time the services are rendered unless other arrangements are made in advance. Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these services.

**MONTHLY STATEMENT:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**INSURANCE:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company for 60 days as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. **If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it and presenting it at the time of service.** If you do not bring a referral, you will be expected to pay at the time of service.

**RE-BILLING FEE:** A re-billing fee will be imposed on each account that is over thirty days past-due.

**MISSED APPOINTMENT FEE:** If you are unable to keep your appointment, or cancel with less than 24 hours notice, we are unable to offer this appointment to other patients. Therefore, we currently charge \$25.00 for a missed appointment.

**PAST DUE ACCOUNTS:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer your account to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

**ASSIGNMENT OF BENEFITS:** I authorize payment of medical benefits to **Matossian Eye Associates** for professional services rendered. I understand I am financially responsible for all charges not covered by my insurance.

Signed \_\_\_\_\_

**RELEASE OF INFORMATION:** I authorize the release of any and all information necessary to process my insurance claim.

Signed \_\_\_\_\_

**DIVORCE:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**TRANSFERRING OF RECORDS:** You will need to request in writing, and pay a reasonable copying fee, if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**EMERGENCY FEE:** If you are seen on an emergency basis, there may be an additional fee (currently \$25.00) that is added to your services. In some cases, insurance will pay that fee, but if they do not, you are responsible for payment.

**WORKERS COMPENSATION:** We require written/verbal authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**PERSONAL INJURY:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

**RETURNED CHECKS:** There is a fee, (currently \$25.00), for any checks returned by the bank.