Desert Vista Eye Specialists, PC

Dr. Lawrence S. Kahn, M.D
certified, American Board of Opthamology
Dr. Stuart Eason, M.D
certified, American Board of Opthamology

PATIENT REGISTRATION

Last Name _____ First Name _____ MI _____

Address 1 _____

City _____ State _____ Zip _____

Address 2 _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

SS# _____ Age _____ DOB _____ M F Marital Status S M D W

Occupation _____ Employer _____ Retired _____

Address _____

City _____ State _____ Zip _____

Spouse or Parents Name _____ Primary Care Physician _____

Emergency Contact _____ Phone _____

Address _____

INSURED PERSON

Last Name _____ First Name _____ MI _____

Address 1 _____

City _____ State _____ Zip _____

SS# _____ DOB _____ Employer _____

Address _____

City _____ State _____ Zip _____

INSURANCE: Failure to supply the correct Insurance at the time of service will result in patient responsibility.

Primary Insurance Co. name _____ ID# _____

Subscriber's Name _____ DOB _____ Relationship _____

Subscriber's Employer _____ Plan# _____ Group # _____

Secondary Insurance Co. name _____ ID# _____

Subscriber's Name _____ DOB _____ Relationship _____

Subscriber's Employer _____ Plan# _____ Group # _____

SIGNATURE REQUIRED ON BACK

How did you hear about us? □ Web □ Friend □ Newspaper □ Health plan directory □ Patient □ Physician □ Family member

2450 E. Guadalupe #107
Gilbert AZ 85234
P: 480-507-0600
F: 480-558-7162
www.desertvistaeye.com

Desert Vista Eye Specialists, PC

Dr. Lawrence S. Kahn, M.D
certified, American Board of Opthamology
Dr. Stuart Eason, M.D
certified, American Board of Opthamology

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. MEDICARE: I requested that payment of authorized medicare benefits be made on my behalf to Desert Vista Eye specialists, PC, for services furnished me by Desert Vista Eye specialists, PC. I authorize any holder of medical formation about me to release to the centers for medicare and Medicaid services(formerly health care financing administration) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claims forms, my signature authorizes releasing the information to the insurer or agency shown. Desert Vista Eye Specialists, PC accepts the charge determination of the medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductibles are based upon the charge determination of the medicare carrier.

2. MEDIGAP: I understand that if a Medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Desert Vista Eye Specialists PC, if possible or otherwise to me.

3. RELEASE OF INFORMATION: Desert Vista Eye Specialists, PC may disclose all or any part of my medical record and / or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under direct contract to Desert Vista Eye Specialists, PC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Desert Vista Eye Specialists PC, may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Desert Vista Eye Specialists, PC maintains a list of health care service plans with which it contracts. A list of such plans in available from the business office. And that Desert Vista Eye Specialists, PC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Desert Vista Eye Specialists, PC if I belong to a plan that does not appear on the above-mentioned list.

5. NON COVERED CHARGES: I understand that Desert Vista Eye Specialists, PC contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items and services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefits summary the health care service plan furnishes to the patient: and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with the Desert Vista Eye Specialists, PC to obtain necessary health care service plan authorization.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Desert Vista Eye Specialists, PC I will pay my account at the time of service or will financial arrangements satisfactory to Desert Vista Eye Specialists, PC for payment. If an account is sent to a collection agency or to an attorney for collection, I agree to pay collection expenses and / or reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I maybe charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring that patient, or any other party liable to the patient, is hereby assigned to Desert Vista Eye Specialists, PC. If co payments and /or deductibles are designated by my insurance company or health plan, I agree to pay them to Desert Vista Eye Specialists, PC. However, it is understood that the undersigned and / or the patient are primarily responsible for the payment of my bill.

7. CANCELLATION POLICY: I understand and agree that I will give 24 hours notice if unable to make scheduled appointment. A charge of $25.00 will be assessed to my account for missed or broken appointments without 24 hours notice.

8. INSUFFICIENT FUND POLICY: I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payments thereafter, and I will be obligated to pay a returned check fee of $25.00.

9. PRIVACY STATEMENT: I understand that I have been given the opportunity to view the privacy policy. I understand that if I desire a copy, one shall be given to me by the office staff. The policy is located on the wall in the waiting room.

Beneficiary Signature or Authorized Party _____ **Date** _____

2450 E. Guadalupe #107
Gilbert AZ 85234
P: 480-507-0600
F: 480-558-7162
www.desertvistaeye.com