PACIFIC EYE ASSOCIATES

2100 Webster St., Suite 214
San Francisco, CA 94115
http://www.pacificeye.com

(415) 923-3007 phone
(415) 923-6586 fax
eyeservices@pacificeye.com

PATIENT REGISTRATION FORM

Patient Name:

Date of Birth:_____/_____/_____ **Sex:** _____

Social Security #:_____/_____/_____
☐ Decline

Patient Address:

State ID/Driver's License: _____- _____

Marital Status: _____

Emergency Contact Info:

Name: _____

Relation: _____

Phone #: _____

Primary Phone #: ( ) _____ - _____
[Home | work | mobile | other] Please circle

Secondary Phone #: ( ) _____ - _____
[Home | work | mobile | other] Please circle

Email Address:_____ ☐ Decline
(Note: By providing your email address, you consent to be added to our patient portal.)

PREFERRED CONTACT METHOD: ☐ Home ☐ Work ☐ Mobile ☐ Mail ☐ Patient Portal

RACE: ☐ Asian ☐ African American ☐ American Indian ☐ Caucasian
☐ Hispanic ☐ Pacific Islander ☐ Other:_____ ☐ Decline

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Decline

LANGUAGE: ☐ English ☐ Cantonese ☐ Mandarin ☐ Russian
☐ Other:_____ ☐ Decline

Primary Insurance: _____

ID #:_____

Primary Care Physician: _____

Phone #: _____

Secondary Insurance: _____

ID #:_____

Referring Physician: _____

Phone #: _____

Other Insurance/ Vision Plan: _____

Optometrist: _____

How did you hear about us: ☐ Primary Care Physician ☐ Optometrist ☐ NP/PA/Another Physician
☐ Another Patient ☐ Relative ☐ My Insurance ☐ Yellow Pages/YP.com
☐ Pacific Eye Website ☐ Internet ☐ Clinic/Hospital ☐ Other: _____

☐ NO CHANGES _____
Pt initial

Please see back

PACIFIC EYE ASSOCIATES

Patient Conditions, Consent, Financial Agreements, Acknowledgement of Privacy Practices (V4)

Medical and Surgical Consent: The undersigned consents to medical/surgical treatment which may be performed, including dilating drops, diagnostic procedures, anesthesia, medical or surgical treatment or procedures rendered to the undersigned under the general and special instructions of the patient's physician, assistants, or designees. The undersigned also agrees that Pacific Eye Associates may obtain electronic files from other healthcare providers or third party benefit payers of any results or information necessary to render treatment, such as health information, diagnostic test results or prescription medications.

Release of Information: For purposes of determining liability for payment and obtaining reimbursement, the patient (or the patient's legal representative) agrees that Pacific Eye Associates may disclose the patient's record, including their medical records, to any person, corporation, governmental body or other entity which is or may be liable, or which is involved in ruling on liability or who may assume or has assumed liability for all or any portion of charges including but not limited to: insurance companies, health care service plans, workers' agencies.

Assignment of Health Plan Benefits: The patient (or patient's representative) hereby assigns to Pacific Eye Associates any health insurance or health plan benefits payable to the patient (or to the patient's representative) by an insurer or health plan for the medical/surgical treatment provided to the patient. The patient (or patient's representative) signing below authorizes any health plan or health insurer to pay directly to Pacific Eye Associates for such services. This assignment pertains to benefits payable for health care costs or services of any kind payable from any source. The patient (or patient's representative) agrees not to interfere with Pacific Eye Associates' ability to rightfully obtain payment from any health plan or insurer. Nothing herein shall be construed as altering or modifying in any way the patient's responsibility for payment in full for goods and services received.

Medicare Patients Only: Patient's Certification, Authorization to Release Information, and Payment Request
I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or other related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Financial Agreement: I certify that I am eligible for benefits under the insurance plan shown on the reverse side of this form (if listed) and I hereby authorize payment of medical insurance benefits due to myself or my dependents to Pacific Eye Associates. I recognize that it is my responsibility to check with my insurance carrier or health care service plan prior to obtaining services to discover whether or not services are covered. I understand that I am responsible for co-payments, deductible amounts, non-covered services, and any other fees not paid by my insurance at the time services are provided. I agree that I am fully responsible for payment for services provided by Pacific Eye Associates if I fail to obtain proper authorization, referral or pre-certification necessary under my insurance plan, if I fail to make the requisite inquiry to determine whether or not services are covered, or to verify that the physician I am seeing is a provider for my insurance plan.

Cancellation fees may be assessed if appointments for office visits or elective surgical services are not cancelled in advance. A billing fee of $25 or more may be assessed if copays are not paid at the time of service. Past due balances may be assessed 18% interest 60 days after: the date services were provided (if private pay) or the initial billing date subsequent to the receipt of any insurance payments. Accounts referred to any attorney or agency for collection may be assessed fees for collection and interest on unpaid balances. I acknowledge my responsibility for these additional fees should they become necessary.

The undersigned certifies that he/she has read for foregoing and is the patient or is duly authorized by the patient (as the patient's parent or general agent) to execute the above and accept its terms.

_____ _____
Patient's Signature Signature of Responsible Party or Agent (for the patient)

_____ _____
Date Signed Relationship to Patient Witness

The undersigned further certifies that he/she:

Received a copy of Pacific Eye Associates Notice of Privacy Practices

Was Notified of California Law Regarding Interpreter Services for English Deficient Patients

_____ _____
Patient Signature Date Patient Signature Date