# Dressler Ophthalmology Associates, PLC
# Patient Registration Form

## *Demographic

First_____ MI____ Last _____ Date of Birth _____

Street _____ Home (  ) _____

City_____State_____Zip_____ Work (  ) _____

Social Security # _____ Cell (  ) _____

(  ) Single  (  ) Female  Employer _____

(  ) Married  (  ) Male

Referring Physician _____ Phone (  ) _____

## *Primary Medical Insurance : _____

Name of Policy Holder _____ Date of Birth _____ M (  ) F (  )

Policy Holders Social Security # _____

Patient's Relationship to Insured: (  ) Self (  ) Spouse (  ) Child

Insurance ID # _____

Insurance Group # _____

## *Secondary Medical Insurance : _____

Name of Policy Holder _____ Date of Birth _____ M (  ) F (  )

Policy Holders Social Security # _____

Patient's Relationship to Insured: (  ) Self (  ) Spouse (  ) Child

Insurance ID # _____

Insurance Group # _____

# Release of Medical Information
# Assignment of Benefits
# Payment Agreement

I authorize Dressler Ophthalmology Associates, PLC to release any medical information to my insurance carrier that is necessary for the processing of my medical insurance claim.

I authorize and request that payment of my medical insurance benefits be made on my behalf directly to Dressler Ophthalmology Associates, PLC.

It is understood and agreed that I will reimburse Dressler Ophthalmology Associates, PLC for the costs of any and all copayments, co-insurance, deductibles, non-covered services, non-medically necessary services, non-allowed services, and any other costs not reimbursed in full by my insurance carrier within 30 days of receipt of an account statement. I understand that if my payment is not received by the designated due date, then my account will accrue a $25 late fee for each billing cycle that it is past due that I must pay in full to clear my account balance.

## Notice of Privacy Practices Under HIPAA

Receipt of Dressler Ophthalmology Associates' Notice of Privacy Practices under HIPAA is hereby acknowledged.

## HMO Patients

It is understood that if I have an HMO insurance policy, I will need to bring a referral from my primary care provider for each of my appointments. I understand that it is the patient's responsibility to obtain a referral and if one is not presented at the time of my appointment, I will be asked to either reschedule or pay for the visit in full by providing a copy of my credit card for the charges. If Dressler Ophthalmology Associates, PLC does not participate with my primary medical insurance carrier, or whether they are considered in-network or out-of-network, I understand that I will be responsible for the entire outstanding balance on the account that is not reimbursed by my primary and or secondary/tertiary insurance.

## Legal and Collection Costs

I understand and agree that should Dressler Ophthalmology Associates, PLC be required to undertake legal action to recover payments for my medical services, I am fully responsible for all late payment fees, collection costs, legal and court costs incurred at that effort, and interest calculated from the date of service. I understand that once an account is turned over to the collection agency, in order to clear my account, I will have to pay the amount in full, all costs included, directly to the collection agency, and they will transfer the payment information to Dressler Ophthalmology Associates, PLC.

## Cancellation and No Show Policy

I agree to pay a $50.00 fee for appointments not cancelled within a full 24 hour notice. I understand that even if the appointment is rescheduled, if it is less than a 24 hour reschedule, then I must still pay the $50.00 fee before making another appointment or being seen.

Patient Printed Name: _____

Signature: _____ Date:_____