PATIENT REGISTRATION FORM -- WORCESTER EYE CONSULTANTS (WEC)

Patient Name_____ Gender: **Male** **Female**

Email address: _____ SS# _____

Mailing Address_____ Date of Birth _____

City_____ State_____ Zip _____

☐ **IMPORTANT – <u>If any seasonal / partial year mailing addresses, check box and list on reverse side</u>**

Phone: Home _____Cell _____Work_____

Primary care:_____ Who recommended WEC _____

Is this visit for a <u>WORK RELATED</u> injury? Yes No If yes, please complete next line:

Employer + WC # _____

♦ **<u>PERSON RESPONSIBLE FOR PAYMENT</u>**

Name_____ SS#_____

Relationship to Patient_____ Date of birth _____

Mailing Address_____

City_____ State_____ Zip Code_____

Phone: Home _____Cell _____Work_____

♦ **<u>PRIMARY Insurance Company</u>**

Insurance_____ Group #_____ Subscriber ID #_____

Name of Insured_____ Date of Birth_____

Relationship to Patient_____

♦ **<u>SECONDARY Insurance Company</u>**

Insurance_____ Group #_____ Subscriber ID #_____

Name of Insured_____ Date of Birth_____

Relationship to Patient_____

♦ **How will you pay today for any fees not covered by insurance if any:**

( ) Cash ( ) Credit Card *(MC, Visa, Discover accepted)*

♦ **<u>Insurance copays</u> , <u>deductibles</u>, and <u>fees for non-covered services</u> must always be paid <u>on day of visit</u>.**

ASSIGNMENT AND RELEASE – <u>By signing below I acknowledge I have read and understand all items below:</u>

1) **I authorize this office to release any information necessary to process insurance claims.**
2) **I authorize my insurance benefits for this and future visits to be paid directly to Worcester Eye Consultants.**
3) **I understand that I am financially responsible for all <u>non-covered services</u>, <u>copays</u>, <u>coinsurance</u>, <u>deductibles</u>.**
4) **It is my obligation to call my primary care physician to obtain a referral when necessary for this and future visits. If I do not obtain a referral when one is needed, I will be responsible for payment for services rendered.**
5) **I am responsible to inform this office of any changes in my insurance on all visits and to know which services and providers are covered under my insurance plan or I will be responsible for payment for services received.**
6) **I understand that I may be charged when I cancel an appointment with less than 2 BUSINESS days notice.**

_____ _____

Signature of Patient or Person Financially Responsible **Date**