Patient Registration

Welcome to our Practice. Please provide the following information.

Last Name	First Name		Date of Birth	
Address		City	State	Zip Code
Home Phone Number	Cell Phone Number	Email Address		
Occupation	Employer		Work Phone Number	

PROTECTED HEALTH INFORMATION RELEASE: Concerning matters of my health, exam results, and appointments, I, the patient/legal representative give permission for The Independent Doctor Next To LensCrafters to speak to and share my information with:

Name_____ Relationship_____

☐ I do not want to share my information with anyone. (Initial)_____

I ☐ ALLOW ☐ DO NOT ALLOW specific information regarding my care to be left on my answering machine or voicemail.

HIPAA ACKNOWDEDGEMENT: I have been given, I have reviewed, and I consent to all practices/policies explained in the Notice of Privacy Practices.

Signature: _____

SIGNATURE ON FILE AND FINANCIAL POLICY

I authorize my insurance benefits be paid directly to The Independent Doctor next to LensCrafters. I understand that I am financially responsible for any balance or services not covered by my insurance. I also authorize the Doctor's office and my Insurance company to release any information required to submit my claims. I understand that I am financially responsible for all services rendered

1) My Insurance company's denial of the claim.
2) If I do not have the proper referral at the time of service.
3) If have given incorrect, invalid or incomplete insurance information.
4) If some services are not covered by my insurance.
5) I have not met my deductible.
6) The services rendered are deemed medically unnecessary by my insurance company.

I agree to pay all co-pays and non-covered services and products in full at the time of service. I agree to pay any outstanding balances in full before any continuation of care or any new care is rendered. Failure of my insurance to pay does not excuse my financial responsibility.

Signature: _____

Advanced Beneficiary Notice (ABN)

I understand that my insurance will only pay for covered services. The fact that my insurance will not pay for a particular service does not mean that I should not receive it. I have been informed and educated by the Doctors' staff of the benefits of _____ as well as the fee and Iagree to be personally and fully responsible for payment.

X_____