COUNCIL EYE CARE INC.
4243 TRANSIT ROAD
WILLIAMSVILLE, NY 14221

REGISTRATION

Welcome to Council Eye Care. We ask that you provide us with your most current information. Please fill out the entire form. This is so we can provide you with the best of service. If you are an existing patient with us, we appreciate your patience and understanding as we update all of our files as necessary. Thank you.

PATIENT INFORMATION

Mr. /Mrs./Miss/Ms./Dr.___________________________ ______ __________________________________

FIRST NAME **MI** **LAST NAME**

______/______/______ M / F __________________________ SINGLE / MARRIED / DIVORCED / WIDOWED

DATE OF BIRTH **SEX** **SOCIAL SECURITY NUMBER** **MARITAL STATUS**

_____________________________________ ___________________________ NY ______________

STREET ADDRESS **CITY** **ZIP**

________________________ ________________________ ________________________

HOME PHONE # **WORK/DAYTIME PHONE#** **CELL PHONE #**

EMPLOYMENT STATUS: EMPLOYED FT / EMPLOYED PT / FT STUDENT/ PT STUDENT / NOT EMPLOYED / RETIRED

PRIMARY CARE PHYSICIAN: ____ **PHONE**: ____________________________

EMAIL ADDRESS:

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO STAFF FOR COPYING

PLEASE INDICATE THE PRIMARY INSURANCE: __BLUE CROSS BLUE SHIELD ___SENIOR BLUE __VSP __ INDEPENDENT HEALTH __MEDICAID __MEDICARE __NVA __UNIVERA ___EYEMED ___VBA__OTHER______________

___________________________________ _____________________ ________________

SUBSCRIBER (PRIMARY INSURANCE HOLDER) SUBSCRIBERS DOB SUBSCRIBERS SS#

GUARANTOR INFORMATION (FINANCIAL RESPONSIBLE PARTY)

_________________________ ____________________________ ___________________

NAME ADDRESS PHONE

RELATION TO PATIENT: ________________________________

DISCLAIMER

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Council Eye Care Inc or insurance company to release any information required to process my claims.

____ _________________

PATIENT OR GUARDIAN SIGNATURE TODAY'S DATE

COUNCIL EYE CARE INC
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FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

- All patients must complete our “Registration Sheet”.
- Full payment is due at the time of service.
- All co-payments are due at the time of service. If this is not paid at the time of service, an additional fee of 5$ will be charged.
- We accept cash, check, Visa, MasterCard, Discover and American Express. Returned checks will have an additional charge of $25.00.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. However**, INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** We will inform you if we participate with your insurance company, and will handle your claims according to our agreement with them, if one exists. We file insurance claims as a courtesy to our patients. We WILL NOT become involved in disputes between you and your insurance company regarding deductibles, co-payments, referrals, covered charges, secondary insurance, “usual and customary” charges, etc. other than to supply factual information as necessary.

REGARDING APPOINTMENTS

Once you have made an appointment with us, it is your responsibility to inform us of your current insurance information. If you are seen by our office and have not informed us of any changes that may have occurred with your insurance, you will be charged and expected to pay for the full office visit. You may then submit your receipt on your own to your insurance company for reimbursement.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY

PATIENT/GUARDIAN SIGNATURE________________________________ DATE _________________

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INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Council Eye Care, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Council Eye Care, Inc. may use my health care information and may disclose such information to the insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable to related services.

Patient/Guardian Signature_____________________________ Date _________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ (Patient), date of birth ___________, Social Security Number _______________, acknowledge and agree that I have received a copy of the Council Eye Care Inc. Notice of Privacy Practices.

________________________________ ____________________

Patient/Guardian Signature Date

________________________________ ____________________

Print Name of Guardian (if applicable) Relationship (if applicable)

If this acknowledgement is signed by someone who is not the patient listed at the top of this form, provide a description of the signer's authority to act for the patient:
____
____

FOR OFFICE USE ONLY:

Council Eye Care Inc made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Information Practices:

( ) Patient/Guardian was offered copy and individual refused to accept delivery
( ) Patient/Guardian accepted delivery of copy but refused to sign form to acknowledge Receipt of Notice.
( ) Other

___________________________________ ___________________

Staff Member Signature Date