BYERS EYE CARE | REGISTRATION

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

Preferred Name:_____ Male O | Female O

If under 18 - Parent / Guardian Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Alternate Phone:_____

Emergency Contact Name:_____ Phone:_____

PRIMARY INSURANCE

Name of Primary Insured:_____ Date of Birth:_____

Member ID / SSN:_____ Insurance Company:_____

Employer:_____

SECONDARY INSURANCE

Name of Primary Insured:_____ Date of Birth:_____

Member ID / SSN:_____ Insurance Company:_____

Employer:_____

Permission to Treat	I give Byers Eye Care and its optometrist permission to examine, diagnose, and treat as necessary myself or the minor on this sheet.
Signature-On-File Authorization	I request and authorize that payments made by Medicare or other insurance companies be made to Byers Eye Care on my behalf for any services provided to me by Byers Eye Care or its optometrist.
Responsibility Statement	I further understand that I am responsible for the entire bill for services provided even though insurance has been filed on my behalf. Insurance is filed as a courtesy to our patients and every effort will be made to verify benefits prior to being seen. Insurance co-payments and/or deductibles are due at the time of service. I assume responsibility for all fees that are incurred if my account requires collections or an attorney.
Release of Information	I give permission to Byers Eye Care to release all medical and financial information related to this registration to the following entities: 1: _____ 2: _____ 3: _____ 4: _____
Privacy Policy	I have reviewed and/or have been offered a copy of the Notice of Privacy Policies of Byers Eye Care.

SIGNATURE:_____ **DATE**:_____