TACOMA EYE

Patient Registration Form

Patient Name:_____

Patient date of birth:_____

Patient SSN:_____

Address: _____City/State/Zip:_____

Phone number we can contact you_____

Name of parent/guardian completing form (if applicable):

_____

Email address we can contact you:_____

How did you hear about us? *(A friend, Social Media,Radio)*_____

Vision Plan:	**Medical Insurance:**	**Secondary Medical Insurance:**
Name of Vision Plan	Name of Med Insurance	Secondary Med Insurance
Policy ID#	Policy ID #	Policy ID #
Group #	Group #	Group #
Subscriber name:	Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB	Subscriber DOB
Subscriber SSN:	Subscriber SSN:	Subscriber SSN:
Relationship Between Patient & Subscriber:	Relationship Between Patient & Subscriber:	Relationship Between Patient & Subscriber:

*F*inancially responsible party (patient/parent/guardian) understands & agrees:

Vision plans *(like VSP, Davis Vision, EyeMed) are a form of coverage (like dental coverage) to help defray the cost of eligible eye exams and optical merchandise. I understand* ***medical insurance*** *(like Molina, Regence, Aetna) are medical plans that help cover the exam cost when a medical condition (Cataracts, Vitreous degeneration/Floaters) is detected.*

I agree to make my vision plan and medical insurance details available so eligibility can be verified prior to finalizing my appointment. Tacoma Eye will endeavor to notify patients of ineligible or incomplete data through the phone number and email above. If insurance determines that the information provided is incomplete or invalid or cannot validate my exam prior to the exam, The financially responsible party agrees to pay the usual and customary fees per Tacoma Eye. "Out of Network" or Patients deemed ineligible for coverage by their vision plan or insurer may go to insurance companies to seek reimbursement. Even when eligibility is confirmed, insurance companies still maintain there is no "guarantee" of coverage. The ultimate responsibility of any monetary balance is that of the financially responsible party.

Unless other arrangements are made we request professional services/co-pays on the day of the examination. We request payment in full before orders for optical merchandise (glasses, contact lenses) are placed.

_____ _____

Signature *Date*

TACOMA EYE