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:

IMPORTANT

Vision plans are a form of coverage that help reduce out of pocket costs of eligible eye exams and optical merchandise *(eyewear, contact lenses, etc.)*. **Medical insurance** help reduce out of pocket costs when a medical condition *(cataracts, dry eye, etc.)* is detected. Vision plans and medical insurance are termed "carriers" in this agreement.

The financially responsible party *(patient/patient's parent/guardian)* agrees to:

Make carrier details available so eligibility may be verified prior to an appointment and consent to our office submitting charges to carrier on their behalf. Tacoma Eye will endeavor to verify coverage with carriers but the financially responsible party is responsible to know the coverage limits of their carriers. By not supplying this information, the financially responsible party consents to being billed directly for services performed at Tacoma Eye at the usual and customary rate. If carrier details provided are incomplete, invalid or otherwise ineligible for payment, the financially responsible party consents to being billed directly for services at the usual and customary rate. Tacoma Eye does not coordinate benefits (COB). Carriers dictate to our office which plan is termed primary and the primary carrier will be billed. Patients are welcome to submit an invoice after payment to the secondary carrier to seek reimbursement. "Out of Network" patients or patients deemed ineligible for coverage by their carrier may submit an invoice after payment to their carriers to seek reimbursement. Carriers make it clear that even when eligibility has been confirmed, there is no "guarantee" of coverage. We encourage patients to request an explanation of benefits (EOB) from their carrier in order to maintain transparency and understand what their financial responsibility is for a given service. The ultimate responsibility of any monetary balance is that of the financially responsible party.

I have read and understand above*:*

Signature of financially responsible party *(patient/patient's parent/guardian)*:

_____

Print Name:

_____

Date: _____