Croton Vision Center Patient Registration Form

/ / / O Male O Female

Title *Patient first name* *Last Name*

Address (Number, Street, Apartment

/ /

City *State* *Zip Code*

_____/_____/_____ _____-_____-_____ _____

Date of Birth *Social Security Number* *Home Phone*

_____@_____.com _____

Email (optional) *Cell Phone*

_____ _____

MEDICAL / HEALTH INSURANCE (Oxford, Medicare, etc.) Insured's ID Number

_____ O Self O Spouse O Domestic Partner O Parent O Guardian O Child

Full Name of insured Relationship to Insured

_____ _____

VISION INSURANCE (VSP, Davis Vision, EyeMed, etc.) Insured's ID Number

_____ O Self O Spouse O Domestic Partner O Parent O Guardian O Child

Full Name of insured Relationship to Insured

Acknowledgement of Financial Responsibility

Your insurance policy is a contract between you and your carrier. Some of your services may not be covered. Please make sure you have verified your coverage before services are provided.

- Referrals from your primary doctor must be obtained by you and provided at the time of your visit.
- Co-pays and deductibles will be collected at the time of your visit.
- We have contracts with many, but not all, insurance companies. Medicare or other medical plans without routine vision coverage may deny payment for any services rendered in the absence of actual disease. When eye diseases are diagnosed or suspected, additional testing may be necessary. These tests are not covered by vision plans; however, they may be covered by your medical insurance. If your insurance company declines to pay for any reason, you are responsible for payment.
- Our practice strongly recommends a retinal exam to evaluate the overall health of the eyes. We have new technology that can take a digital image of the retina. The cost of this procedure is $30.
- Contact lens evaluations and fittings are not considered part of a comprehensive eye exam and are the responsibility of the patient. The fees are determined by the level of services that are provided. Unfortunately, we will not be able to provide you with a contact lens prescription without having a contact lens examination.

Please Read:

The above information is true to the best of my knowledge. I authorize my insurance benefits (including Medicare benefits) to be paid directly to ***Croton Vision Center***. I understand that I am financially responsible for any balance. I also authorize ***Croton Vision Center*** or my insurance company to release any information required to process my claims.

HIPPA Written Acknowledgment

I have reviewed the Notice of Privacy Practices. I understand that I have a right to request how my health information will be used or disclosed.

_____ _____

Print Patient Name Print Name of Responsible Party

_____ _____

Today's Date Signature of Responsible Party **(turn over→)**