CUMBERLAND EYE CARE
REGISTRATION FORM

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Last name:	First:	Middle:	Marital status:

Hispanic?	Race: Language:	Spouse's Name: (if applicable)	Birthdate:	Age:	Sex: ☐ M ☐ F

Address:		
Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option):
☐ Doctor referral:
☐ Other:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	☐ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work/Cell phone no.:

EMAIL ADDRESS:

Your email address will not be used for any other purpose than to communicate with you regarding your personal medical records and/or to notify you of your appointment dates and times.

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 CUMBERLAND EYE CARE or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

FINANCIAL POLICY

I authorize payment of surgical and medical benefits to Cumberland Eye Care. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V, XVIII, and or XIX of the Social Security Act is correct.

I agree to pay for all non-covered charges, co-pays, co-insurance, deductibles, out-of-network charges, and refractions (the measurement of the eye in order to obtain a prescription for contacts or glasses) at the time of service or when otherwise advised. If this is not possible, I agree to contact the Patient Accounts department BEFORE services are rendered.

I will provide a copy of my most recent insurance card at the time of EACH visit. If I do not provide valid insurance information at the time of EACH visit and my insurance company subsequently denies the claim, I agree to be personally responsible for any and all charges.

I voluntarily consent to healthcare treatment from the physicians and staff at Cumberland Eye Care. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and operations.

Patient/Guardian Signature _____ Date _____

I hereby authorize you to release information regarding my treatment, diagnosis, appointments, financial status and protected health information to the following individuals:

_____

_____

Patient/Guardian Signature _____ Date _____