Patient Registration

CAPE FEAR CATARACT & CORNEA

Your Name as it Appears on Your Insurance Card

First Name | Middle Name | Last Name | Suffix

Date of Birth

mm-dd-yyyy

Date

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Gender

- ○ Male
- ○ Female

Martial Status

- ○ Married
- ○ Single
- ○ Divorced
- ○ Separated
- ○ Widowed

Home Phone Number

Cell Phone Number

Social Security Number

Work Phone Number

Email

example@example.com

Emergency Contact Information

Name

Phone

Relationship

I authorize my emergency contact to discuss and receive information regarding my person health information:

- [ ] General / Medical / Surgical
- [ ] Insurance and Billing

Who is your Optometrist?

Office Location

Who is your Primary Care Doctor?

Office Location

Which pharmacy do you use?

Location

Race

- ◯ White/Caucasian
- ◯ Black/African American
- ◯ Asian
- ◯ Decline to Answer
- ◯ Other

Ethnicity

- ◯ Hispanic or Latino
- ◯ NOT Hispanic or Latino
- ◯ Decline to Answer

Preferred Language

- ◯ English
- ◯ Other

Insurance Information:

PLEASE BRING YOUR MEDICAL INSURANCE CARDS AND PHOTO ID TO YOUR APPOINTMENT

Primary Insurance

Policyholder Name

Policyholder's Date of Birth

Policyholder's Social Security

Policy ID

Group Number

Secondary Insurance

Policyholder Name

Policyholder's Date of Birth

Policyholder's Social Security

Policy ID

Group Number

Guardian / Parent Information if patient is a minor:

Name

Relationship

Date of Birth

Social Security Number

Phone

Work Phone

Financial Disclosure

Patient Acknowledgement Regarding Precautions Following Dilation

It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend not driving or operating dangerous machinery immediately after dilation. We recommend that someone drive you home or that you wait until your eyes return to normal so that you can drive safely.

Refraction Service and Fee

A refraction (CPT 92015) is necessary to determine the performance of the visual system and is an essential part of the medical eye exam. Although a refraction is also used to determine the need for corrective eyeglasses, this practice performs refractions as a necessary part of the medical exam. A refraction is also necessary to evaluate a patient for surgery. Unfortunately, some insurance plans (including Medicare) DO NOT cover the cost of refractions. In these cases, the patient will be responsible for the refraction fee. The fee for a refraction is $40.00.

A topography (CPT 92025) is also an important part of your evaluation and provides valuable information to your surgeon. This test may not be covered by your insurance and you will be responsibility if not covered. The fee for this test is $50.00.

A REFRACTION IS NOT A COVERED SERVICE BY MEDICARE AND MOST INSURANCE PLANS.

This practice will collect the refraction fee at the time of service if we know that your plan will not cover the cost. If we are unsure if your plan will cover the fee, we will submit the charge to your insurance as a courtesy, HOWEVER you are ultimately responsible for the payment.

All copayments are due at the time of service and will be collected at check-in. Payment toward your deductible will also be due at the time of service. AN ADDITIONAL BILLING FEE OF $20.00 WILL BE ADDED TO YOUR ACCOUNT FOR ANY COPAYMENTS NOT PAID AT THE TIME OF YOUR VISIT.

Insurance and Non-Covered Services

As our patient, we want to provide you with the best care possible. There may be certain services we feel are necessary for the maintenance of good health that will not be covered by your insurance company. You will be expected to pay for any non-covered services. Please be assured we will order only those tests and perform only those services that are necessary for your treatment and care. We may not always know for certain how YOUR insurance company will process YOUR claim.

Please note that verifying your insurance coverage is YOUR responsibility. Please provide copies of your current insurance cards to this office at each visit. If you have a question about your coverage, or how your claim was processed, please contact your insurance provider directly. If we file a claim and it is denied because our services are not covered under your insurance plan, you will be billed directly for all cost associated with your visit.

I have read and understand the above information. I accept full financial responsibility for the cost of any non-covered services, deductibles, co-insurance and copayments and I understand what services I will be required to pay at the time of service. I also understand that an additional fee of $30.00 will be charged to any account that is turned over to the collection agency for non-payment of services.

I authorize the release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to Cape Fear Cataract and Cornea, P.A.

Name

First Name | Last Name

Date

mm-dd-yyyy

Date

Signature

Clear

Submit

HIPAA COMPLIANT