



**EYE CENTER**  
OF NORTHERN COLORADO, P.C.

TODAY'S DATE \_\_\_\_\_

**PATIENT REGISTRATION**

Welcome to Eye Center of Northern Colorado! Please take a few minutes to fill in the important patient information below. In order to protect your confidential medical records and your identity, we require photo identification at registration.

**PATIENT INFORMATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ MALE/FEMALE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_  
Address City State Zip

STREET ADDRESS \_\_\_\_\_  
Address City State Zip

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

PRIMARY DOCTOR \_\_\_\_\_ DRIVERS LICENSE \_\_\_\_\_  
Number State

EMERGENCY CONTACT \_\_\_\_\_  
Name Phone

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_  
(Name of family physician, internist, optometrist, friend, yellow pages, etc.)

**PATIENT INSURANCE INFORMATION**

In order to insure accurate insurance information, we require your current insurance cards to scan.

• PRIMARY INSURANCE CO NAME \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY HOLDER DOB \_\_\_\_\_

• SECONDARY INSURANCE CO NAME \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY HOLDER DOB \_\_\_\_\_

**PERSON RESPONSIBLE FOR PATIENT**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_  
Street or PO Box City State Zip

**(SIGNATURE REQUIRED ON BACK OF FORM)**

## FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. We expect, in turn, that you have the same commitment to your financial responsibility to us. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. However, it is your responsibility to understand your insurance plan, including but not limited to deductibles, copayments, coinsurance, covered services, etc. Any and all financial liability rests with the patient and/or guarantor.

Our office participates with most major insurance plans. We **require** current copies of your insurance card(s) before we will file the claim on your behalf. Incorrect insurance information supplied to us may result in you being responsible for full payment. We will file your primary and secondary claims for you. If we do not participate with your insurance plan, we will file the claim once as a courtesy, and payment is expected at time of service.

Copayments or other patient due amounts are expected at time of service. If you cannot pay at the time of service, a \$10.00 billing fee will be added to your account. Repeat statements are subject to a \$10.00 billing fee. Accounts 30 days past due are subject to collection proceedings unless prior arrangements have been made. Accounts placed for collection will have a delinquent account fee of \$25.00 or 35%, whichever is greater, added before the account is placed with an outside collection agency. Nonpayment of services may result in termination from the practice.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient for payment.

## LIFETIME INSURANCE AUTHORIZATION

I request that payment of Medicare, Medigap or other insurance benefits be made on my behalf to Eye Center of Northern Colorado, P.C. for any services furnished to me by an Eye Center physician or supplier. I authorize Eye Center of Northern Colorado, P.C. to release to my insurance company any information needed to determine benefits payable for related services.

**I understand that I am responsible for all charges regardless of insurance coverage.**

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE RETURN THIS FORM TO THE RECEPTIONIST.  
COPIES OF OUR FINANCIAL AND PRIVACY POLICIES ARE AVAILABLE UPON REQUEST.**