EYE PHYSICIANS OF WASHINGTON

Maxwell Helfgott, M.D. Newell Hargett, M.D. Daniel Pluznik, M.D. Amy Green-Simms, M.D.

REGISTRATION FORM (*please print legibly*)

Last Name:_____ First Name:_____ Middle Init:_____

Address:_____

Billing Address (If different):_____

Home #:_____-_____-_____ Work #:_____-_____-_____ Cell #:_____-_____-_____Email:_____

SSN:_____-____-_____ Sex: _____ Age:_____ Date of Birth:_____ Marital Status:_____

Ethnicity: ___Hispanic ___Non-Hispanic ___Declined

Race: ___American Indian/Alaskan Native ___African-American ___Asian ___Caucasian ___Native Hawaiian/Pacific Islander ___Declined

Primary Language: ___Arabic ___Chinese ___English ___French ___Korean ___Spanish ___Other_____ ___Declined

Employed: ___Yes ___No Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship:_____ Phone :_____-_____-_____

Pharmacy:_____ Location:_____ Phone:_____-_____-_____

Primary Doctor:_____ Phone: _____-_____-_____ Referring Doctor:_____ Phone: _____-____-_____

Insured Name (if different):_____ Date of Birth:_____ SSN:_____-_____-_____

Prescription RX Consent: The patient agrees that Eye Physicians of Washington may request and use their prescription medication history from other healthcare providers of third–party pharmacy benefit payers for treatment purposes.

STATEMENT OF OFFICE POLICY

While we make every effort to practice medicine with our greatest concentration on our patients and their health, we must also pay attention to the standard practices of billing and collection in order to remain a viable practice. We participate with a number of insurance plans and our staff will file your insurance claim if our physicians are participating providers of your insurance carrier's plans. We are not responsible for filing with any insurance not listed on our participating insurance company list which is posted at our front desk, but frequently do so. All co-pay or co-insurance and deductible amounts as well as non-covered services as designated by your insurance carrier are your responsibility. It is your responsibility to check with your insurance company regarding any needed referral and to obtain that referral prior to your appointment. If you are unable to provide your insurance information at the time of your service and do not wish to reschedule your visit, you will be responsible for any charges that may not be paid by your insurance carrier due to lack of appropriate referral or physician information. It is your responsibility to provide up-to-date information.

This office DOES NOT PARTICIPATE WITH ANY vision plans. We will, however, provide you with a fee ticket that has all the necessary service information for you to file your own claim. **The refraction is a $75.00 service** which is a necessary part of any eye exam performed to determine your visual acuity with or without corrective lenses. Many insurance carriers do not cover this charge. If your insurance does not cover this charge, you will be responsible.

Please pay all non-covered fees before you leave. Payment is expected at the time of service. We accept personal checks, cash, Visa, MasterCard and American Express. A finance charge of 1.5% per month may be added to any unpaid balance on accounts over 90 days old. Delinquent accounts may be forwarded to collection agencies and credit bureaus at our discretion. By your signature you understand and accept that personal information as required may be disclosed to these agencies. Patients will be responsible for payment of all reasonable costs of collection (including attorney's fee).
A FEE OF $35.00 WILL BE ASSESED TO YOUR ACCOUNT FOR ALL RETURNED CHECKS.
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I hereby authorize this physician to apply for benefits for covered services rendered. I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy, to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing my insurance. I certify that the information I have reported with regard to my insurance is correct. This authorization may be revoked at any time in writing either by me or my insurance company. I have been given a list of this office's Administrative Office Procedures.

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Signature **Date**

REVISED 3/2/20