Mudgil Eye Associates PATIENT REGISTRATION & OFFICE POLICY FORM

CONSENT TO TREAT: By signing this form, I consent to and authorize Mudgil Eye Associates to treat me. I understand, this could include diagnostic tests and imaging studies in addition to an ophthalmic exam. I understand I have the right to refuse treatment.

RELEASE & ASSIGNMENT OF BENEFITS: I hereby authorize the release of any medical information necessary to process the insurance claim for surgical and or medical services provided to my dependent or me. I further authorize payment of medical benefits directly to Mudgil Eye Associates.

INSURANCE COVERAGE: I understand it is my responsibility to be familiar with my insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. I accept full financial responsibility for all services and products I receive. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred, and I agree that I am financially responsible to make payments in full on the remainder balance if my insurance carrier determines the services I received are not covered, unless otherwise prohibited by state or federal regulations.

REFERRAL: If required by my insurance, I understand it is my responsibility to obtain the referral prior to my visit. If I do not have one, I may sign a waiver stating that I will be responsible for the full payment for the services rendered if my carrier denies the claim(s) for lack of and/or invalid referral. Alternatively, I may reschedule the appointment.

FINANCIAL RESPONSIBILITY: I understand copays, deductibles and/or coinsurance are due at the time of service or promptly paid when billed. There will be a $15 service charge if co-pay, coinsurance or deductible is not paid at the time of the service. We accept cash or credit card as forms of payment. There will be $35 bounced check processing fee. Non-payment for services received may result in collections and/or discharge from the practice.

I understand that there may be services that I receive that may be non-covered or not considered reasonable or necessary by Medicare or other insurers. For example, **REFRACTION** is a procedure necessary for the eye doctor to evaluate your vision and prescribe glasses. Although an important part of your exam, it is excluded from Medicare and many medical insurance plans. We are required to charge you a refraction fee separate from your exam. Payment for non-covered services must be paid at the time of your visit. Self-pay patients must pay at the time of service.

Mudgil Eye Associates does not get involved in domestic/custody disputes. Payment must be made by the guardian/parent bringing the child at the time of the visit.

CONTACT LENS "FITTING": I understand that contact lens "fitting" is not included in a complete eye exam; it is a separate procedure with an additional charge. Payment for fitting will be expected at the time of the service.

MISSED APPOINTMENTS: I value the time set aside by Mudgil Eye Associates to see and treat me and/or dependent. I will notify them no less than 24 hours before my appointment if I am unable to make it to my appointment. I will be charged $50 "no show" fee for not showing up to my appointment. Repeat missed appointments may result in discharge from the practice.

PATIENT AUTHORIZATION: I authorize Mudgil Eye Associates PC to share copies of my records with other physicians as needed for continuity of care. I understand that this is a group practice and other eye doctors may be involved in my eye care. I agree and understand a copy of my medical records including HIV AIDS, behavioral health service, psychiatric care, and treatment for alcohol or drug use will be included as part of my health information. I also agree that Mudgil Eye Associates PC may release my records to crediting or regulatory agencies when those agencies request my records and if law permits.

AUTHORIZATION TO COMMUNICATE PRIVATE HEALTH INFORMATION/HIPAA: I acknowledge that I have been offered HIPAA NOTICE OF PRIVACY PRACTICES for Mudgil Eye Associates, PC and that I authorize the use and disclosure of my health information. I authorize Mudgil Eye Associates to leave messages on my answering machine, Voicemail or with individuals who attend my Primary Phone# or Secondary Phone# on the patient registration form.

Mudgil Eye Associates will share my private health information with family or other members it feels is important and in my best interest to share appointment or eye care information. This means they will answer family member's questions and confirm appointment information if the inquiry is made on behalf of the patient. If you do not agree with our policy, please provide the names of individuals who may answer your phone and with whom we should not share your information _____.

PATIENT'S INFORMATION

Last Name	First	MI		
Date of Birth	Social Security#	Gender: ( ) Male ( ) Female	Marital Status ( ) Married ( ) Single	Occupation
Address	City	State	Zip	
Primary Phone#	Secondary Phone#	Email Address		
Primary Care Physician Name	Primary Care Phone #	Pharmacy Name, Address & Phone#		
Employers Name & Address		Work Phone#		

PRIMARY INSURANCE

Insurance Name & Address			
Policy #	Group#		
Policy Holder's Name	Relationship to Patient	Social Security#	**DOB**
Policy Holder's Address (if different than patient)	City	State	Zip

SECONDARY INSURANCE

Insurance Name & Address			
Policy #	Group#		
Policy Holder's Name	Relationship to Patient	Social Security#	DOB
Policy Holder's Address (if different than patient)	City	State	Zip

PEDIATRIC PATIENT ONLY - GUARANTOR'S INFORMATION

Guarantor's Name	Relationship to Patient	Social Security#	**DOB**
Guarantor's Address (if different than patient)			

By signing below, I (guardian, if bringing minor) am in agreement with the above-mentioned policies and understand that it is my responsibility to notify in writing any changes to this Authorization.

X _____ Date:_____