

PATIENT REGISTRATION

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FIRST _____ M.I. _____ LAST _____ BIRTH _____
STREET _____ HOME () _____
CITY _____ STATE _____ ZIP _____ WORK () _____
SOCIAL SECURITY # _____ CELL () _____
() SINGLE () FEMALE EMPLOYER _____
() MARRIED () MALE ADDRESS _____
() OTHER () STUDENT CITY _____ STATE _____ ZIP _____

REFERRING PHYSICIAN _____ PHONE () _____

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PRIMARY INSURANCE _____
INSURED _____ BIRTH _____ MALE FEMALE
INSURED'S SOCIAL SECURITY # _____
PATIENT'S RELATIONSHIP TO INSURED: () SPOUSE () DEPENDANT () SELF
PATIENT ID # _____ CO-PAY _____
GROUP ID # _____ DEDUCT _____
P.O. BOX _____ PHONE () _____
STREET _____ EFF DATE _____
CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE _____
INSURED _____ BIRTH _____ MALE FEMALE
INSURED'S SOCIAL SECURITY # _____
PATIENT'S RELATIONSHIP TO INSURED: () SPOUSE () DEPENDANT () SELF
PATIENT ID # _____ CO-PAY _____
GROUP ID # _____ DEDUCT _____
P.O. BOX _____ PHONE () _____
STREET _____ EFF DATE _____
CITY _____ STATE _____ ZIP _____

**AFTER COMPLETING THIS SIDE,
PLEASE READ AND SIGN THE BACK**

Linda Dressler, M.D. • Daniel Geller, M.D.

Jacqueline Fredrick, O.D.

**RELEASE OF MEDICAL INFORMATION
ASSIGNMENT OF BENEFITS
PAYMENT AGREEMENT**

I authorize DR. DRESSLER, DR. GELLER and DR. FREDRICK to release any medical information to my insurance carrier, that is necessary for the processing of my medical insurance claim.

I authorize and request that payment of my medical insurance benefits be made on my behalf directly to DR. DRESSLER, DR. GELLER and DR. FREDRICK.

It is understood and agreed that this authorization is valid for all medical services provided by DR. DRESSLER, DR. GELLER and DR. FREDRICK until revoked in writing by the undersigned patient or authorized agent.

It is understood and agreed that I will reimburse DR. DRESSLER, DR. GELLER and DR. FREDRICK for the costs of any and all co-payments, co-insurance, deductibles, non-covered services, non-allowed services, excluded services, denials due to pre-existing conditions, denials due to elective services, and any other costs not reimbursed in full by my insurance carrier within 15 days of receipt of an account statement.

NOTICE OF PRIVACY PRACTICES UNDER HIPAA

Receipt of Dressler Ophthalmology Associates Notice of Privacy Practices, under HIPAA is hereby acknowledged.

CANCELLATION - NO SHOW POLICY

I agree to pay a \$25.00 fee for appointments not cancelled with twenty four hours notice.

**HMO ** IPA
PATIENTS**

If DR. DRESSLER, DR. GELLER and DR. FREDRICK do not participate with my primary insurance carrier, I understand that I will be responsible for the entire outstanding balance of the account that is not reimbursed by my primary or secondary insurance.

I agree to pay, in full, for all medical services provided that are not authorized by the insurance carrier and that are provided on my behalf without a referral from my Primary Care Physician. I understand that it is my responsibility to provide the Primary Care Physician. I understand that it is my responsibility to provide the Primary Care Referral at the time of service.

Dressler Ophthalmology Associates does not participate in any routine eye care plans.

LEGAL AND COLLECTION COSTS

I understand and agree that should DR. DRESSLER, DR. GELLER or DR. FREDRICK be required to undertake legal action to recover payments for my medical services I am responsible for all collection, legal and court costs incurred in that effort, and interest calculated from the date of service.

PRINT NAME _____

SIGNATURE _____ DATE _____