

**PATIENT REGISTRATION**

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FIRST \_\_\_\_\_ M.I. \_\_\_\_ LAST \_\_\_\_\_ BIRTH \_\_\_\_\_  
STREET \_\_\_\_\_ HOME ( ) \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ WORK ( ) \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
( ) 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** \_\_\_\_\_

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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 OF THE YELLOW COPY**

***Linda Dressler, M.D. • Daniel Geller, M.D. • Maria Braun, M.D.***

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

I authorize DR. DRESSLER, DR. GELLER and DR. BRAUN 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. BRAUN .

It is understood and agreed that this authorization is valid for all medical services provided by DR. DRESSLER, DR. GELLER and DR. BRAUN 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. BRAUN 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 10 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.

**HMO \* \* IPA  
PATIENTS**

If DR. DRESSLER, DR. GELLER and DR. BRAUN 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 and secondary insurance carrier.

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.

**LEGAL AND COLLECTION COSTS**

It is understood and agreed that should DR. DRESSLER, DR. GELLER and DR. BRAUN 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 \_\_\_\_\_