BRAUN EYECARE PATIENT REGISTRATION FORM

Patient Information

Name_____ Today's Date_____ / _____ / _____

Address_____ Birth Date: _____ / _____ / _____

_____ Home Phone #:_____

Email Address: _____ Cell Phone #: _____

Patient Social Security Number_____-_____-_____ Gender: Male Female

Reason for today's visit ? _____

INSURANCE INFORMATION

Primary **Vision** Insurance: _____ Primary **Medical** Insurance: _____

Subscriber Name: _____ Subscriber Name: _____DOB:_____

Subscriber Birth Date: _____ Insurance ID Number: _____

Subscriber SSN: _____ Subscriber SSN: _____

Do you participate in flex spending plan? Yes No

(Please let us know if you have double coverage for vision or medical insurance so that we may coordinate benefits.)

Authorization and Consent

I consent to evaluation and treatment as mutually agreed upon for the above named patient.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. If we are providers for your insurance plan, we will bill your insurance carrier as a courtesy to you. However, co-pays, deductibles, and the payment of any non-covered service will be due at the time of service. If we are not providers of your insurance plan, payment will be due at the time of service, and we will provide you with an itemized statement, with which you can bill your insurance carrier.

Insurance authorization

- **Insurance cards must be presented at the time of service**.
- **I authorize and request that insurance benefits be made directly to Braun Eyecare on my behalf for any services furnished to me by Dr. Bruce Johnson or Dr. Nicholas Davis.**
- **I authorize the release of all medical records and any insurance information between Braun Eyecare, my family physician, insurance carriers and the Health Care Financing Administration to process claims for related services.**
- **I allow for fax transmission and electronic submission of such information.**
- **If we accept assignment on your insurance policy the physician agrees to accept the charge determination of the carrier as the full charge. The patient is responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and deductibles are based on the charge determination of the carrier.**
- **Signature below is acknowledgement that you have received this Notice of Privacy Practice**.

I have read and fully understand the above consent for evaluation and treatment, financial responsibility, and release of medical/insurance information.

Print Name: _____**Date:** _____

Signature: _____**Parent /Guardian (if under 18)**