Patient Registration

Pacific ClearVision Institute   Clinic: Eugene   Oakridge   Cottage Grove

Patient Information

Last name: ______________________ First name: ______________________ Middle initial: ________

Address: ______________________ City/State/Zip: ______________________

Home phone: ______________ Work phone: ______________ Cell phone: ______________

Email address: ______________________ Patient SSN: ______________ Gender: M / F

Marital Status (circle one) ___Single Married Divorced Widowed   Date of Birth (month/day/year) ______________

Ethnicity: African American Asian Caucasian Latino Other: ______________________

Responsible Party Information

Last name: ______________________ First name: ______________ SSN: ______________

Address: ______________________ City/State/Zip: ______________________

Home phone: ______________ Work phone: ______________ Cell phone: ______________

Date of Birth (month/day/year): ______________ Relationship to Patient: ______________________

Emergency Contact

Last name: ______________ First name: ______________ Relationship to Patient: ______________

Home phone: ______________ Work phone: ______________ Cell phone: ______________

Primary Insurance Information

Insurance Company: ____

Address: ______________________ City/State/Zip: ______________________

Subscriber Name: ______________________ Subscriber Date of Birth (month/day/year) ______________

ID #: ______________________ Group #: ______________________

Subscriber SSN: ___/______/______ Employer: ______________________ Effective date: ______________

Secondary Insurance Information

Insurance Company: ____

Address: ______________________ City/State/Zip: ______________________

Subscriber Name: ______________________ Subscriber Date of Birth (month/day/year) ______________

ID #: ______________________ Group #: ______________________

Subscriber SSN: ___/______/______ Employer: ______________ Effective date: ______________________

Primary Care Physician

Name: ______________________________________ Phone: ______________________

Specific Disclosure Consent: voluntary consent to disclosure of health information to the following people

Name: ______________ Name: ______________ Name: ______________

I authorize the doctors and staff of PCVI to use and disclose my health information as necessary in order to provide treatment, obtain payment, and conduct healthcare operations. I acknowledge that I have received the notice of Privacy Practices from Pacific ClearVision Institute (PCVI). In addition, I authorize PCVI to reach out to me to request occasional feedback by email or text message. In addition, I authorize PCVI to occasionally request feedback from me via text or email.

Signature: ______________________________________ Date: ______________

Business and Credit Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

As a service to our patients, we bill primary and secondary insurance directly. Please understand that insurance coverage is an agreement between you and your insurance company. We will assist in resolving any problems that may arise for payment of your claims, but do require you to be the lead advocate in the process.

If you are a new patient to our office, please note that our office will call to verify your insurance benefit package prior to your first appointment. We will notify you of the patient portion due at the time of your visit based on your individual insurance policy. Co-payments are due at the time of each visit. Our office accepts Visa, MasterCard, American Express, and Discover Cards for your convenience. We request that the balance be paid within 30 days of your receipt of our statement.

If a primary physician referral is required by your insurance policy to see a specialist in our practice, we ask that you ensure ALL information (name of referring physician, insurance ID#, and name of employer) has been provided, and assist in contacting your primary physician's office to initiate the process. If you do not have a referral in place and choose to still be seen by one of our doctors, we will require you to sign a waiver and pay at the time services are rendered.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our business office. This will avoid misunderstandings and enable you to keep your account in good standing. Our business office phone number is (541) 687-9007.

A parent or legal guardian must accompany minor patients to all appointments.

I have read, understand, and agree to the above Business and Credit Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to the applicable physician that rendered medical services. I also request payment of government benefits either to myself or to the party who accepts assignment.

______________________________ ______________

Responsible / Insured person, parent, or guardian Date

(IF NOT IN THE PRESENCE OF PARENT OR GUARDIAN)

Any Practitioner of Pacific ClearVision Institute

May unconditionally treat: ______________________________ ____/____/____

(patient name) (birth date)

In my presence or absence without reservation.

______________________________ ______________________________

Signature Relationship