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).

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