Pacific ClearVision INSTITUTE

# PATIENT REGISTRATION

❑ EUGENE
❑ OAKRIDGE
❑ COTTAGE GROVE

## Patient Information

Last Name | First Name | Middle Initial

Address | City | State | Zip

Primary Phone | Work Phone | Email

Patient SSN | Date of Birth (MONTH | DAY | YEAR)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Gender: ❑ Male ❑ Female

Ethnicity: ❑ African American ❑ Asian ❑ Caucasian ❑ Latino

❑ Other: _____

Primary Care Physician Name | Primary Care Physician Phone

Emergency Contact Name | Relationship to Patient

Emergency Contact Primary Phone | Emergency Contact Work Phone

## Referral

We'd love to know how you heard about us or who referred you! _____

## Responsible Party Information

Responsible Party Last Name | Responsible Party First Name | Relationship to Patient

Responsible Party Address | City | State | Zip

Responsible Party Primary Phone | Work Phone | Email

Responsible Party SSN | Responsible Party Date of Birth (MONTH | DAY | YEAR)

## Primary Insurance Information

Primary Insurance Company Name | ID# | Group #

Primary Insurance Address | City | State | Zip

Subscriber Name | Subscriber Date of Birth | Subscriber SSN

Subscriber Employer Name | Effective Date (MONTH | DAY | YEAR)

## Secondary Insurance Information

Secondary Insurance Company Name | ID# | Group #

Secondary Insurance Company Address | City | State | Zip

Subscriber Name | Subscriber Date of Birth | Subscriber SSN

Subscriber Employer Name | Effective Date (MONTH | DAY | YEAR)

## Specific Disclosure Consent - Voluntary Consent to Disclose Health Information to the Following People:

Name:_____ Name:_____ Name:_____

I authorize the doctors and staff of Pacific ClearVision Institute ("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 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 541.343.5000.

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 Party | Subscriber | Parent or Guardian** **Date**

(IF NOT IN THE PRESENCE OF PARENT OR GUARDIAN)

Any Practitioner of Pacific ClearVision Institute may unconditionally treat:

_____ _____

Patient Name Date of Birth (MONTH | DAY | YEAR)

In my presence or absence without reservation.

_____ _____

Signature Relationship