PATIENT REGISTRATION

NAME:____HOME PHONE:______________________

ADDRESS:_____________________________________WORK PHONE:______________________

CITY:______________________ST:_____ZIP:__________CELL PHONE:______________________

SEX: M F MARITAL STATUS:____________ RACE/ETHNICITY:______________________

DOB:____________SSN:______________________ EMPLOYED: Y N SCHOOL: FT PT

EMPLOYER/SCHOOL NAME:________________________OCCUPATION:___________________

REFERRAL SOURCE:_____________________PRIMARY CARE PHYSICIAN:___________________

EMERGENCY CONTACT NAME:_______________________PHONE (H):____________________

RELATIONSHIP TO PATIENT:_______________________OTHER PHONE:____________________

HEALTHCARE DURABLE POWER OF ATTORNEY (if applicable):__________________________

RELATIONSHIP TO PATIENT:______________________________PHONE:_____________________

PATIENT E-MAIL ADDRESS:____

PRIMARY INSURANCE:__________________________________PHONE:_____________________

ID NUMBER:________________________________GROUP NUMBER:______________________

POLICY HOLDER NAME:______________________POLICY HOLDER SSN:___________________

RELATIONSHIP TO PATIENT:_______________________SEX: M F DOB:_______________

ADDRESS:____PHONE:_____________________

EMPLOYER/SCHOOL NAME:____________________________EMPLOYER'S INS PLAN: Y N

SECONDARY INSURANCE:________________________________PHONE:____________________

ID NUMBER:__________________________________GROUP NUMBER:_____________________

POLICY HOLDER NAME:_______________________POLICY HOLDER SSN:__________________

RELATIONSHIP TO PATIENT:_________________________SEX: M F DOB:______________

ADDRESS:____PHONE:____________________

EMPLOYER/SCHOOL NAME:____________________________EMPLOYER'S INS PLAN: Y N

CONDITIONS OF REGISTRATION

The Practice
Reston Eye Associates, PLLC and/or its physicians (e.g. Elle Milani, MD), employees, or assignees will hereafter be referred to as "REA".

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS
I do hereby authorize REA to apply for benefits for services rendered to myself or minor child under Medicare or any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to REA (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to REA. I authorize REA to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

RELEASE OF MEDICAL INFORMATION
I authorize REA to release any and all of my or my minor child's medical records and/or other information and records required by my insurance company or its designated review agents who provide insurance benefits on my behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, the Health Care Financing Administration or Medicare (CMS), needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to REA; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child's medical records and/or other records and information on myself or my minor child to REA as required for payment of benefits and/or required for medical or any other reasons; and authorize REA to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied. Such charges are not to exceed 0.50 per page for the first 50 pages and 0.25 per page thereafter in addition to a $10.00 regular postage/handling fee.

REFERRALS AND AUTHORIZATIONS
If I have an insurance plan that requires any referrals, pre-certifications or authorizations I understand that it is my responsibility and not REA's to obtain approval from my insurance plan for medical services and/or procedures prior to such medical services and/or procedures being rendered. Some insurance companies may take up to 48 hours or more to obtain a referral. Additionally, if any aforementioned procedures are not done and medical services and/or procedures are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for the claims. I understand and agree that I am financially responsible for any charges not paid by my insurance plan or not covered under the terms of my policy. Any denial of claims is between the policyholder/subscriber and their insurance. I agree to inform REA immediately of any change in insurance coverage and/or benefits and change of personal information. I understand medical services may not be rendered without the proper referral on file.

MEDICARE PATIENTS
I understand that in certain circumstances, Medicare may decide that appropriate medical services are not medically necessary under the Medicare law. Since Medicare will deny payment for these services, such as routine vision services and refraction, I agree to be personally and fully responsible for payment of these services.

ROUTINE SERVICES AND VISION PLANS
REA does not participate with vision service plans such as Davis Vision, Vision Service Plan (VSP) or routine vision services for Cigna patients. Vision service plans typically cover routine services, such as refraction, eye check-ups, contact lenses fitting or replacement, or other non-medically necessary services. I agree to be personally and fully responsible for payment of these services in case of denial of coverage for such benefits by the insurance carrier.

FINANCIAL AGREEMENT
I agree that payment in full is due at the time of treatment. I the undersigned further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by myself, my children, step children or any other extended family members, including but not limited to grandchildren, nieces and nephews. I also understand that I may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. REA will file for insurance benefits and accept payments per REA's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by REA is given strictly as a courtesy and implies no responsibility on REA's part for filing, follow through or confirmation. I agree to pay a $10.00 billing fee for each payment, including copayments and co-insurance, not made at time of visit. I agree to pay the Emergency/Walk-in fee of $50.00 in addition to the office visit if I arrive without an appointment. I agree to pay a $20.00 fee for any forms, such as DMV forms, that are filled out by REA on my behalf. I agree to pay a $25.00 fee for missed appointments that are not cancelled at least 24 hours in advance. Should any balances arise due to insurance copayments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services. Interest of 1.5% per month, 18% per year, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my account are not made, I authorize REA to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my delinquencies. I understand that this will affect my credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection fee, plus court costs and interest in the amount of 1.5% per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I assume full responsibility. I understand and agree that the terms herein are reaffirmed each time services are received.

COPY OF SIGNATURE
I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION
I certify that the information I have reported with regard to my insurance coverage is correct and that the above be honored by my insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the foregoing and understand and fully accept the terms therein. I certify the information I have reported on the front of this document is correct.

I certify that as the Patient/Parent/Guardian/Guarantor I have read, understand, and fully accept the Conditions of Registration above.

______________________	______________________________	______________________
Signature	Print Name & Relationship to Patient	Date