CHAO VISION INSTITUTE

Commitment ◆ Expertise ◆ Integrity

PATIENT REGISTRATION

REFERRED BY

❑ Dr. _____ ❑ CVI PT:_____ ❑ Other (Specify) _____

PATIENT INFORMATION

NAME (Last, First, MI) _____ Birthdate (mm/dd/yy) _____ Sex ❑ M ❑ F

Title ❑ Dr. ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Employer _____

Address _____ Ph (Home) _____ Ph (Cell) _____

City/ St/ Zip _____ Email _____ Fax _____

EMERGENCY CONTACT:

NAME (Last, First) _____ Ph (Cell) _____ Relationship _____

INSURANCE COMPANY INFORMATION

❑ Self-Pay/ No Direct Ins. Co Billing ❑ Direct Bill Primary Ins Co. Only

GUARANTOR NAME (Last, First) _____ Birthdate (mm/dd/yy) _____ Sex ❑ M ❑ F

Home Address _____ City/ St/ Zip _____

PRIMARY Ins Co Name _____ SSN/ ID _____ PLAN No _____

2ND Ins Co Name _____ SSN/ ID _____ PLAN No _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have reviewed the Notice of Privacy Practices that describes how Chao Vision Institute uses and discloses my protected health information. I am aware that a printed copy is available on the website at www.chaovision.com or upon request.

CONFIDENTIALITY AND BENEFITS, ASSIGNMENT AND RELEASE

I, the undersign certify that I (or my dependent) have insurance coverage and assign directly to Chao Vision Institute, Inc. Medical Associates all insurance benefit to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I understand that my records are confidential and my signature authorizes the doctor to release all information necessary for the purpose of healthcare, insurance operation and to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to Chao Vision Institute, Medical Associates, Inc. for any services furnished to me by their doctor. I authorize any holder of medical information about me to be released to Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is only responsible for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient/ Representative	Signature of Witness
Relationship to patient	Date