GINSBERG EYE
OPHTHALMOLOGY

Location
☐ Olde Naples
☐ Estero

Provider _____

PATIENT REGISTRATION

How did you hear about our practice? Please circle and be specific.

Search Engine — Google • Bing • Yahoo • DuckDuckGo
Social Media — FB • Instagram
Our Website
Magazine
NCH ER
Insurance
Current Patient _____
Family/Friend _____
Referring Physician _____

Name_____ Date of Appointment_____
Last First M.I.

Mailing Address_____ Age_____
Street Address Apartment Number

_____
City State Zip code

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Email_____

Date of Birth ___/___/___ SS#_____ Marital Status_____ Gender_____

Occupation_____ Place of Employment _____

Spouse's Name:_____ Employer_____ Work #_____

Person to notify in case of emergency_____ Phone_____

Do you have a cosmetic or anti-aging concern (i.e. fine lines, loss of volume, texture)? Y N
Have you had a cosmetic or anti-aging treatment in the past (i.e. Botox, Dysport, or Fillers)? Y N
Would you be interested in hearing about Facial Harmonization treatments offered at our practice? Y N
Are you interested in upper eyelid surgery? Y N
Are you interested in freedom from glasses or contact lenses? Y N

May we discuss your medical condition with another person? Y N

If yes, whom_____ Relationship_____

May we discuss your medical insurance benefits and billing information with another person? Y N

If yes, whom_____ Relationship_____

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Primary Insurance _____ ID# _____

Secondary Insurance _____ ID# _____

Policy Holder (if different from patient or responsible party) _____

Policy Holder's Date of Birth ___/___/___

Patient's Relationship to Policy Holder _____

Agreement of Responsibility

I understand that professional services, diagnostic tests and other medical services rendered to the patient are the financial responsibility of the patient or the patient's guarantor (the responsible party in the case of minors). I understand that I am financially responsible for all charges not covered by my insurance company.

Eyeglass Prescription(Refraction)

I understand that a refraction is a service that is not covered by Medicare or most health insurance carriers. If your doctor provides a refraction with an eyeglass prescription, you will be responsible for this charge, which is payable at the time of service of $75.00.

Lifetime Consent to Treat

I voluntarily consent to such care and treatment as prescribed by Ginsberg Eye providers as is necessary in the judgment of Barrett R. Ginsberg, M.D., Suzana Akemi Tanimoto, PA-C, Richard F. Beatty, M.D. and Prissilla S. Issa, O.D. I voluntarily consent to in-office minor procedures as prescribed by a provider of Ginsberg Eye. I understand/ expect that all procedures including the risks and benefits, will be thoroughly discussed with me prior to the procedure.

Release of Information Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to any of my insurance companies. I permit a copy of this to be used in place of the original. I authorize the provider to act as an agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement in disputed claims. I assign any rights and claims. I assign any rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will received a monthly statement for any balance due by me.

I hereby authorize, its agents, employees and affiliates to have access to my complete medical records for the purpose of performing its billing and management functions as they deem necessary.

Medicare Authorization (if applicable)

I request payment of authorized Medicare benefits be made on my behalf to, for any services furnished to me by that physician or supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary and pay the claim. If "other health insurance" is indicated in the HCFA form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the 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 responsible only for the deducible, co-insurance and any uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization (if applicable)

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient.

Patient Signature: _____ Date:_____