OPHTHALMIC CONSULTANTS OF VERMONT

Gregory McCormick, MD • Cataract, Cornea & Refractive Surgery
Katherine Lane, MD • Cosmetic, Oculofacial Plastic & Reconstructive Surgery
David Shiple, MD • Cataract, Cornea & Comprehensive Ophthalmology

VERMONT LASER VISION AT TIMBER LANE

PATIENT REGISTRATION FORM

PATIENT INFORMATION PLEASE COMPLETE (FILL OUT) ENTIRE FORM			
LAST NAME	FIRST NAME		MI
MAILING ADDRESS	CITY	STATE	ZIP
STREET ADDRESS (if different from mailing)	CITY	STATE	ZIP

DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS	GENDER
HOME PHONE	CELL PHONE	ALTERNATE PHONE	
PREFERRED NUMBER ☐ HOME ☐ CELL	EMAIL ADDRESS		

PRIMARY CARE PHYSICIAN	OPTOMETRIST	OTHER OPHTHALMOLOGIST
REFERRING DOCTOR	PRIMARY LANGUAGE (If not English)	INTERPRETER NEEDED? ☐ YES ☐ NO

RESPONSIBLE PARTY (ANY PATIENT UNDER 18 MUST HAVE RESPONSIBLE PARTY)			
☐ Patient (18 years or older) ☐ Custodial Parent ☐ Guardian (proof of legal status required)			
LAST NAME	FIRST NAME		MI
MAILING ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH	PHONE NUMBER

MEDICAL INSURANCE INFORMATION

☐ I currently have Medical insurance– **Please bring insurance card(s) to appointment**

☐ I currently do not have Medical Insurance- You are responsible for balance at time of visit

☐ Workers Compensation or Auto Insurance- Please bring claim information to visit

NOTE:

Our office does not participate with *Vision Service Plans, Aetna, United Health Care, &Tricare*

Please contact your insurance to verify your Out of Network Benefits or if a referral is required

(PLEASE TURN OVER)

Verified By:

Staff Initials:_____

Please review the following and sign:

Consent for Payment & Financial Responsibility

I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to my physician or supplier for services provided.

- If we are not participating providers with your insurance company, your insurance may process visits at a higher out of pocket rate. We will submit a claim directly to your insurance company for reimbursement.
- I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to the office for payment. If the payment is sent to me, I will forward this payment to the office immediately. If payment is not received by the office within 45 days, a statement will be sent to me. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility.
- I understand and agree that regardless of my insurance, I am in the end responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and the practice of Ophthalmic Consultants of Vermont, incurs collection charges, they will be my responsibility.

Consent under Vermont Law for Purposes of Treatment and Healthcare Operations

You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

- By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Ophthalmic Consultants of Vermont provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- My Protected Health Information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
- You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.
- *It is the office policy of Ophthalmic Consultants of Vermont not to release confidential medical information regarding your treatment to family members or friends*. **If you anticipate that you will need or want your medical information to be provided to your family members, friends, or caretakers/babysitters, please indicate below:**

Spouse: _____ Yes No Phone: _____

Parent: _____ Yes No Phone: _____

Other: _____ Yes No Phone: _____

_____ Yes No Phone: _____

We would like to contact you from time to time for Post visit follow up and Appointment reminders

May we contact you via text message? Yes No

May we contact you via email? Yes No

REQUIRED

Name of Patient: _____ Date of Birth: _____

Patient Signature: _____Date: _____

Parent/Guardian: _____

Parent/Guardian Signature: _____Date: _____