New Jersey Vision Associates, P.C.
Mitchell Vogel, M.D., F.A.C.S.

124 Gregory Avenue, Suite 104
Passaic, NJ 07055-4856

PATIENT REGISTRATION FORM

Welcome to our practice. All information below is necessary to properly submit and process your claims. Please fill out all information on the front and back of this form. CMS requires providers to report race and ethnicity. Thank you.

PATIENT INFORMATION

Name: _____ **Social Security #:**_____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Date of Birth:** _____

Home Phone #: _____ **Cell Phone #:** _____

Marital Status: Single Married Widowed Divorced **E-Mail Address:** _____

Gender: M F Preferred Language (Circle One): English / Spanish / Other: _____

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian or Pacific Islander / Other / I decline to answer

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Employer: _____ **Occupation:** _____

Employer Address: _____ **Phone:** _____

Emergency Contact Name: _____ **Phone:** _____

Patient's Pharmacy Name and Address: _____

Patient's Primary Care Physician: _____ **Phone:** _____

How were you referred to our practice?: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Name: _____ **ID#** _____

Subscriber: Self Spouse Parent **Subscriber Name/DOB:** _____

Secondary Insurance Name: _____ **ID#** _____

Subscriber: Self Spouse Parent **Subscriber Name/DOB:** _____

Please present your insurance cards and any insurance referral if necessary to the receptionist so that we can scan them into our practice management system for billing purposes. The patient's copayment is to be paid at the time of the visit.

_____ _____

Responsible Party Signature **Date**

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name_____ Insurance ID#_____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to New Jersey Vision Associates, P.C. for services furnished me by New Jersey Vision Associates, P.C. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand 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 CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. New Jersey Vision Associates, P.C. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the **deductible, coinsurance, and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.**

2. MEDIGAP: I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to New Jersey Vision Associates, P.C.

3. RELEASE OF INFORMATION: New Jersey Vision Associates, P.C. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to New Jersey Vision Associates, P.C. for reimbursement for services rendered, and (2) any health care provider for continued patient care. New Jersey Vision Associates, P.C. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that New Jersey Vision Associates, P.C. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that New Jersey Vision Associates, P.C. has no contract, expressed or implied, with any plan that does not appear on the list. **The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by New Jersey Vision Associates, P.C., if I belong to a plan that does not appear on the above mentioned list.**

5. NON-COVERED SERVICES: I understand that New Jersey Vision Associates, P.C.'s contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items and services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with New Jersey Vision Associates, P.C. to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patinet by New Jersey Vision Associates, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to New Jersey Vision Associates, P.C. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to New Jersey Vision Associates, P.C**. If copayments, coinsurances, and/or deductibles are designated by my insurance company or health plan, I agree to pay them to New Jersey Vision Associates, P.C. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of the bill.**

Patient signature or authorized party_____ Date_____