Registration : Morganton Eye Physicians, PA

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home:	How did you hear of us?
Address 2	Work:	
	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Provider **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Morganton Eye Physicians, PA , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Morganton Eye Physicians, PA	
X		335 East Parker Road Morganton, NC 28655	Phone: 828-433-1000 Email:

Please attach all pertinent insurance ID cards for photocopying.

Billing & Insurance Information

As a service to our patients, our doctors participate with most major insurance plans, and we gladly accept Medicare assignment. For the convenience of our patients, we are pleased to file insurance claims on your behalf directly to Medicare and most other major insurance carriers. However, in order for us to assist you in receiving benefit coverage from your insurance carrier; you must help us by respecting our payment and billing policies.

In order for Morganton Eye Physicians, P.A. (MEPPA) to process insurance claims on your behalf, it is necessary for you to provide copies of your insurance cards or other documentation which includes the name, address, phone number, group number, and policy number for your insurance coverage. If you are unable to provide a copy of a valid insurance card, we will be unable to file a claim on your behalf and will require full payment for all services and products delivered to you on the date the service/product is provided.

Payment in full is due at the time services are provided. If you are a Medicare participant or have other insurance which you believe will provide benefit coverage for the services/products provided to you by our doctors, you will be required to pay applicable deductibles, co-payments, co-insurance and/or other payment amounts necessary on the date the services/products are provided to you.

If we believe that a service/product provided to you will be considered "non-covered" by your insurance carrier, we will require payment on the date the service/product is provided to you.

Typically, medical insurance, including Medicare, does not provide coverage for routine eye examinations or contact lens fittings. Unless your insurance card or other documentation specifies coverage for routine examinations or contact lens fittings, we require full payment on the date services are provided to you.

A 50% deposit is required on all eyeglass orders. Please note that we do not dispense eyeglasses unless payment is received in full. Contact lens orders must be prepaid in full.

For your convenience, we accept cash, checks, money orders, MasterCard, Visa, American Express and Discover payments. We are also pleased to help arrange financing through an independent finance agency for laser vision correction and cosmetic surgery.

Release of Information, Assignment of Benefits and Acknowledgment of Financial Responsibility

I, as the patient, or the guardian or guarantor of the patient, acknowledge that I have read and agree to the following:

I hereby authorize MEPPA to release any and all necessary medical information relevant to my medical condition, diagnosis or status as a patient required by federal, state and/or third party insurance providers necessary to document my eligibility for benefit coverage, process insurance claims, or as required for quality assurance programs, claim resolution procedures or other insurance mandated programs or activities my doctor is required to participate in order to received payment from your insurance carrier.

I understand and agree that I am personally responsible to MEPPA for MEPPA's usual and customary fee charged for service/products provided to me. Payment is required on the date the service/product is provided to me. If MEPPA has entered into a contract with my insurance carrier to accept an amount less than MEPPA's usual and customary fee, I understand and agree that I will continue to be responsible to MEPPA for any and all applicable deductibles, co-payments, co-insurance, or other required payment amounts based on the adjusted fee agreed to between MEPPA and my insurance carrier. If MEPPA does not participate with my insurance carrier, or a service/product is determined to be "non-covered" by a contracted insurance carrier, I understand and agree that I am responsible for MEPPA's usual and customary fee for such service/product provided to me.

For Medicare assigned claims, MEPPA agrees to accept the Medicare "allowed" amount for services/products provided to me. I understand and agree that I am financially responsible to MEPPA for any and all applicable deductibles, co-payments, co-insurance, or other required payment amounts based on the Medicare "allowed" amount. If a service/product is not eligible for coverage by Medicare, or is determined to be a "non-covered" service by Medicare, I will be responsible for MEPPA's usual and customary fee for such service/product provided to me.

I hereby direct and authorize that payment of my medical and/or surgical benefits, including but not limited to Medicare, Medicaid, Medigap and Medicare supplemental coverage, governmental, agency and/or private commercial insurance(s), be made on my behalf to directly to MEPPA.

_____ _____

Patient Signature Date

_____ _____

Guardian or Guarantor's Signature (if applicable) Date

Marketing Materials

I, as the patient, or the guardian of the patient, Do Not wish to receive any information regarding the services, products, or promotions offered by MEPPA. I may, at any time, make a written request to be added to future mailing lists.

_____ _____

Patient, Guardian or Guarantor's Signature (if applicable) Date