Registration : Center For Eyecare LLC

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?
	Work:	
Address 2	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician | 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 Center For Eyecare LLC **,** 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	Center For Eyecare LLC
X		123 Egg Harbor Rd, Suite 300 Phone: 856-290-4548
		Sewell, NJ 08080 Email:

Please attach all pertinent insurance ID cards for photocopying.

CENTER for EYECARE
Eye Physicians and Surgeons

DR. RAYMOND M. GIRGIS, M.D., F.A.A.O.
Diplomate American Board of Ophthalmology
Specializing in Comprehensive Ophthalmology

DR. SHOSHANA NYQUIST, M.D., F.A.A.O.
Diplomate American Board of Ophthalmology
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Please Read Carefully

Standard Contact Lens Fitting

Our Standard contact lens fitting costs between $125.00 and $175.00 and includes the following:

1. A Contact lens fitting exam. The doctor takes specific measurements of the eye for the right contact lens fit. (This is not to be confused with a regular eye exam.)

2. A pair of trail contact lenses which will help determine the correct contact lens fit.

3. A contact lens check. The patient returns to the office after wearing the trail contacts for about a week. The contact lenses need to be in the eyes for this contact check.

4. Training and instruction on how to use and care for the contact lenses.

5. A follow-up appointment directly related to the contact lens fitting, if needed.

Please note that most insurance companies do not cover the cost of contact lenses or the contact lens fitting. Some vision plans do include the contact lens fitting in the total contact lens allowance, but only if contacts are actually ordered.

Please note: Fitting for the hard contact lenses (Rigid Gas Permeable) costs $175.00 and does not include free trail lenses.

It is the patient's responsibility to know whether or not he or she is covered by a vision plan, and to know the name of that vision plan.

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PATIENT'S NAME_____

SOCIAL SECURITY #_____

Authorization For Medical Treatment
Signature On File—Third Party Insurance

I hereby authorize the physicians and designated paraprofessional employees of CENTER FOR EYECARE, L.L.C. to perform such examinations, and treatments as are necessary to care for the medical condition of the patient, now and in the future.

Authorization is hereby granted to release to a third party with legitimate interest such information as may be necessary for the completion of medical insurance/disability forms. I authorize use of this form on all my insurance submissions now and in the future unless I explicitly rescind this authorization in writing.

I certify that no guarantee or assurance has been made as to the outcome of the results that may be obtained, nor is one expected.

I hereby authorize payment directly to CENTER FOR EYECARE, L.L.C. and all benefits payable to me under the terms of my insurance policy for treatment or services provided to me or my dependents. I understand that I am financially responsible for any balances or charges not covered by my insurance company, Medicare or other.

This **authorization must be signed by the patient or by an authorized person** in the case of a minor or when patient is physically or mentally incompetent.

SIGNATURE_____DATE_____/_____/_____

WITNESS_____

Insurance Signature On File

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me."

I am also responsible for my deductible and co-insurance not payable by Medicare or any other insurance which includes the $25.00 charge for the eye refraction which is a non-covered service.

SIGNATURE_____DATE_____/_____/_____