REDWOOD EYE CENTER
2852 REDWOOD PARKWAY
VALLEJO, CA 94591
(707) 553-8222

Welcome to our office. We are committed to the best, most comprehensive care possible. We encourage you to ask questions. Let us know your concerns and communicate openly with us. Please assist us by providing the following information. All information is confidential and is only released with your consent. Please fill in blanks below the lines.

NEW PATIENT INFORMATION ***TODAY'S DATE:***

Patient Name: Last Name		First Name		MI
Home Address:		City	State	Zip
Social Security #	Date of Birth	Sex: M / F	Marital Status: S / M / LS / D / W	
Personal Physician's Name		Home Phone		
Mailing Address If Different Than Above		Work Phone		

RESPONSIBLE PARTY IF DIFFERENT THAN ABOVE

Last Name		First Name	
Address	City	State	Zip
Home Phone		Work Phone	
Relation		Social Security #	

INSURANCE COMPANY

Subscriber's Last Name		First Name	MI
Relation	Social Security #	DOB	Sex: M / F
Policy or I.D. # Group #			
Employer			

SECONDARY INSURANCE

Subscriber's Last Name		First Name	MI
DOB	Policy or I.D. #	Group #	

MISCELLANEOUS INFORMATION

Driver's License #		E-Mail Address:	
Alternate Phone #:	Home	Work	Cell / Pager
Employer's Name		Occupation	
Address			
Spouse's Name			
Employer			

PLEASE READ OUR FINANCIAL POLICY STATEMENT AND AGREEMENT ON REVERSE

ALL CO-PAYMENTS OR DEDUCTIBLES ARE DUE AT THE TIME SERVICE IS PROVIDED IN OUR OFFICE.

IF YOU DO NOT HAVE INSURANCE, YOUR PAYMENT IS DUE AT THE TIME THE SERVICE IS PROVIDED.

MEDICARE PATIENTS: SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made on my behalf to (provider / supplier listed) for any services furnished me by the listed provider / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to 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 HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. As Medicare Participating Providers, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print):

Provider, Name, Address & Zip:

Patient's Signature:

Redwood Eye Center
2852 Redwood Pkwy.
Vallejo, CA 94591

Patient's Medicare No.: Date:

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurances please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to: REDWOOD EYE CENTER. I am hereby informed that my claim may be billed electronically to my Insurance Carrier or via the Internet. I understand that my medical records are confidential. I understand that by signing below, I am allowing my medical information to be released upon my Insurance Company's request. I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. This assignment/consent will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature _____ Date _____

VSP PATIENTS: I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon VSP's request, to VSP, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

For additional information on VSP's Patient Confidentiality Policy, please refer to; www.vsp.com. VSP updates the patient Confidentiality Policy periodically and reserves the right to make changes as required.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Signature _____ Date _____

I have read, understand and agree to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Signature _____ Date _____