



Eyes of Oregon - Lake Oswego

David A. Biggar, OD

2 Centerpointe Dr #150
Lake Oswego, OR 97035
Ph: 503-639-3937 Fx: 503-620-4448

PATIENT REGISTRATION

MR MRS MISS MS DOC

Male Female

First Name	MI	Last Name	Preferred Name
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Street Address	City	State	Zip
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Last 4 of Soc Sec	Date of Birth	Email Address
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Best Contact Phone #	2nd Best Contact Phone #	Can we e-mail you reminders for your appointments?
circle Cell Home Work	Cell Home Work Email	Yes No

Emergency contact	Relationship to patient	Phone #:
		Hobbies: _____

How did you hear about us? _____

Payment Policy: Payment is required when services are rendered. Patient portion of glasses and contacts is due when materials are ordered. \$25 fee for returned checks. Accounts are charged a \$10 monthly billing fee. Accounts not paid in full within 120 days of service are considered delinquent. Delinquent accounts are assessed \$50 for collection efforts and are reported to credit bureaus.

Insurance Policy: As a courtesy we bill most insurance companies. Insurance is a contract between you and the insurance company. We try to determine your benefits, but cannot control accuracy of the information we receive. Medicare and insurance companies will only pay for services they determine to be "reasonable and necessary" and "covered" under your plan. If payment is denied we will assist you to get your maximum benefit, but you are ultimately responsible for all charges.

Double Coverage: Because insurance companies handle double coverage in ways we cannot predict, we may require payment based on your primary coverage and have you receive reimbursement directly from the second company.

Cancellation Policy: If you are unable to keep any future appointments please call us as soon as possible. If you do not give us 24 hour notice a \$25 donation to the Optometry Giving Sight is collected in lieu of a No Show Fee. This donation helps five needy people receive the gift of sight (eye exam & glasses). www.GivingSight.org for more information.

Employer: _____	Occupation: _____
<u>Vision Insurance</u>	<u>Medical Insurance</u>
Carrier: _____	Carrier: _____
Primary Insured/DOB: _____	Primary Insured/DOB: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Eyes of Oregon. I understand that I am financially responsible for all charges. I also authorize Eyes of Oregon and my insurance company to release any information required to process claims.

X

Patient/Guardian signature: _____	Date: _____
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