MOSAIC
EYE SPECIALISTS

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Today's date:						
Patient's Last name:	First:	M.I.:	☐ Dr. ☐ Mr.	☐ Mrs. ☐ Ms.	Marital status (circle one) Single / Married / Divorced Separated / Widowed	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		Birth date: / /		Age:	Sex: ❑ M ❑ F
Email address:						
Street address:			Social Security no.:		Home phone no.: ( )	
City:	State:		ZIP Code:		**Cell phone no.:** ( )	
Occupation:	Employer:				Work phone no.: ( )	
I chose this clinic because/Referred to clinic by (please check one or more boxes from the following two rows)			❑ Dr. (print doctor's name below)		❑ Insurance Plan	❑ Hospital
❑ Family ❑ Friend	❑ Close to home/work	❑ Internet (If yes, Yelp? Y / N)	❑ Other (Please Specify Below)			
Emergency Contact:			Emergency Phone:		( )	

MEDICAL INSURANCE INFORMATION: **Please bring your insurance cards with you** and provide all pertinent insurance information to our receptionist. If you have coverage by more than one carrier, please supply information on both carriers. **Please provide us with the insurance subscriber's date of birth if you aren't the subscriber:** _____.

The "Refraction" portion of an eye examination (the exam for glasses) is not covered by Medicare or by many insurance companies and may be required to make a diagnosis or to give you a prescription for glasses. ***Payment for the refraction is the patient's responsibility.* **Our refraction fee is $75.00**.**

Please initial here to confirm receipt of our refraction policy. _____

Your Pupils may be dilated as part of your Eye Exam. This exam is very important to examine the structures in the back of the eye, including the retina, blood vessels, and optic nerve. This may create mild temporary blurriness lasting approximately 1-4 hours. Please plan on bringing a driver if this has bothered you in the past. Complimentary sunglasses are available upon request.

SIGNATURE ON FILE

_____ _____

Patient's name (print) Insurance Subscriber ID/Medicare Ident. No.

I request that payment of authorized insurance/Medicare benefits be made on my behalf to **Mosaic Eye Specialists, P.C.** or to **Dr. Adam H. Dao** or to **Dr. Thomas W. Eck** for services furnished to me by **Mosaic Eye Specialists.** We will file your insurance for you as a service. We will make every attempt to determine your eligibility and benefits, *but it is the patient's responsibility to know their insurance benefits*.

I hereby authorize **Mosaic Eye Specialists, P.C.** to furnish my insurance company and secondary insurance company, if applicable, or health plan all necessary information concerning me or my dependent necessary to secure the payment of benefits for services rendered. I hereby assign to Mosaic Eye Specialists, P.C. and/or Dr. Adam H. Dao all monies to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to him.

In general, Dr. Dao does **not take HMO commercial insurances or insurances that require a referral from your primary care physician (e.g. Aetna HMO, Molina, etc.), and does not take many Medicare HMO Advantage Plans. Many patients are either switching or are being switched without their and our knowledge to "**Narrow Medical Provider Networks**" which we do **not** participate in. **If you have one of these plans, please see the receptionist to confirm Dr. Dao's and Dr. Eck's participation with your plan.**

If you have changed Health Care Plans or have been switched to a plan or network that we are not a part of, be advised that we are not liable and you will be responsible for all charges due for medical services rendered. **It is the patient's responsibility to know the specifics of their health care plan and the medical providers included in that plan's network.**

I am responsible for any deductibles, copays, coinsurance, charges for non-covered services, and/ or charges incurred if I have signed my benefits over to another person or organization such as an HMO, and have not informed Dr. Dao or Dr. Eck's office.

_____ _____

Patient/Guardian Signature Date