NORTH IDAHO EYE INSTITUTE

Patient Registration Form

PATIENT INFORMATION

Patient ID# _____

Patient's Name: _____ Date of Birth: _____ Age: _____
First Initial Last

Social Security #: _____ Sex: [ ]M [ ]F Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ County: _____

Home Phone: _____ Cell Phone: _____ Preferred: Home Cell

☐ I do not want text messages for appointment reminders sent to my cell phone number listed above.

Race: [ ] White [ ]American Indian or Alaska Native [ ]Pacific Islander [ ]Black or African American [ ] Asian Other Race: _____

Ethnicity: [ ] Hispanic [ ] Non-Hispanic or Latino [ ] Decline Language: _____

Pharmacy : _____ Employer: _____ Phone: _____

Referring Physician: _____ Personal/Family Physician: _____

EMERGENCY CONTACT

Name:

Phone:

Relationship:

RESPONSIBLE PARTY INFORMATION

☐ Same as patient information listed above.

Responsible Party:		Patient Relationship:	
Date of Birth:		Social Security #:	
Address:		City, State, Zip: ,	
Employer:		Phone:	

PRIMARY INSURANCE			SECONDARY INSURANCE	
Insurance Name:			Insurance Name:	
ID Number:			ID Number:	
Group Number:			Group Number:	
Subscriber Name:			Subscriber Name:	
Date of Birth:			Date of Birth:	

Person(s) with who(m) we may share your healthcare information: (Living facility, child, caregiver, spouse?)

Name: _____ Date of birth: _____

Name/Facility: _____ Date of birth: _____

I hereby certify that the above information is true and accurate to the best of my knowledge.

Patient/Responsible Party Signature: X _____ Date: _____

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Insurance Authorization Agreement

I authorize North Idaho Eye Institute, North Idaho Cataract and Laser Center, and/or Coeur d'Alene Optical to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution, and other healthcare operations to appropriate agencies, including collections agencies, insurance companies and third-party payers. I understand I have the choice of where I have my surgery completed, and that the North Idaho Cataract and Laser Center is owned by Dr. Tad Buckland, Dr. Alison Granier, Dr. David Dance, Dr. Sara Duke, Dr. Whitney Smith Myers, and Dr. Drew Thomas.

I authorize treatment of the person named on this form, I certify that I am the patient or legal guardian and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly unless payment arrangements are made. I understand that I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable and failure to pay will resort in my account being turned over to a collection agency.

Insurance and Financial Statement

North Idaho Eye Institute and North Idaho Cataract & Laser Center all accept Medicare, Idaho Medicaid as well as many commercial insurances. If you do not have insurance, or a secondary insurance that covers your deductible and/or coinsurance, you will be expected to pay your copay and/or coinsurance at the time of service.

Refractions are not covered by Medicare and may not be covered by your insurance. You are responsible for the refraction charge of $45.00 and is due at the time of service.

A no show fee of $50 for a clinic appointment and $250 for a surgery appointment will occur for not showing within 15 minutes of your scheduled appointment. Failure to show for your appointments may result in a fee posted to your account and must be paid prior to rescheduling. More than 3 no shows may result in dismissal from our practice.

It is the patient's responsibility to ensure that appropriate referral information from the insurance company is sent to our office before your visit. If referral is not present at the time of service, you may be asked to re-schedule.

Idaho Medicaid does not provide routine vision care to patients over the age of 21. By signing below, you agree to and understand that you will be financially responsible for routine vision care provided if your insurance does not cover the services rendered.

If you have any questions, or need to set up payment arrangements please contact our billing office at 208-667-5540.

I hereby certify that I have read the above agreement and statement and agree to adhere to the terms above. I have reviewed the above policies and information and verify that the information I provided is the correct information to the best of my knowledge.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of Provider's Notices of Privacy Practices with the effective date of 01/01/2024.

Printed name: _____

Signature: _____ Date: _____