907 376-2020
Fax: 907 357-3937
4505 E Greenstreet Cir
Wasilla AK 99654

Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
Jessica Thornton, OD
Yennhi Tran, OD
Evan Wolf, MD PhD

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information.
(Please Print)

Patient First Name Middle Initial Last Name	Sex Male ☐ Female ☐	Date of Birth	Marital Status (circle) S M W D

Race:	Ethnicity: ☐ Hispanic or Latin ☐ Unknown ☐ Non-Hispanic or Latin	Primary Language:	Email:

Mailing Address City State Zip	Home Phone:	Social Security #

Name of employer Address	Business Phone	Occupation

Name of Spouse/Parent	Date of Birth	Social Security #	Business Phone

Reason for visit	How were you referred to this office?

Person to contact in case of emergency	Relationship to patient	Phone

Primary Insurance Coverage

Primary Insurance Company	Address	Social Security #

Subscriber Name	Subscriber birth date	Policy #	Group #

Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary Insurance Coverage

Secondary Insurance Company	Address	Social Security #

Subscriber Name	Subscriber birth date	Policy #	Group #

Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured Self ☐ Spouse ☐ Child ☐ Other ☐

I authorize any holder of medical or other information about me to release to my health or vision insurance, including Medicare, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to assignment of benefits apply.
I understand that I am financially responsible for any charges not covered by insurance. If I default on my account balance, I understand my account will be forwarded to Cornerstone Collection Agency.

_____ _____
Patient Signature **Date**

****PLEASE SEE REVERSE SIDE FOR BILLING POLICY AND SIGNATURE****

Thank you for choosing Wolf Eye Center as your eye care provider.

You'll See The Difference!

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BILLING POLICY & PROCEDURE

Patient Name:_____ Date:_____

This document was prepared to assist patients with the financial policies of Wolf Eye Center, Inc. Please read and initial each item and then sign in the space provided. Should you have further questions our staff will gladly assist.

Billing

- You authorize payment of medical benefits to Wolf Eye Center for any/all services provided to you by the physician. You understand that you are financially responsible for any amount not covered by your insurance plan. You authorize Wolf Eye Center to release information concerning your health care, advice, treatment, and/or supplies to your insurance company and/or it's agents for the purpose of evaluating and administering claims. _____
- It is your responsibility to provide all of your insurance information. Without complete insurance information, Wolf Eye Center cannot bill for services and you will be responsible for your balance. _____
- Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your coverage, etc. except to supply factual information as needed. _____
- Wolf Eye Center is a "preferred provider" for the following insurances: Medicare, Medicaid, Blue Cross, EBMS/PEHT, Tricare, VA and VSP. If your insurance is not one of these, please be aware that your claim will likely be processed as "out of network". _____
- Your co-pay and any unmet deductible will be collected at time of service. If we cannot verify what your co-pay is, we will collect 20% of your balance. _____
- If proof of insurance cannot be provided, payment will be due in full. For payment in full at time of service, we do offer a discount. If you are unable to pay in full at time of service, you must establish an approved payment plan with the Wolf Eye Center billing department. All payment plans must be paid in full within 120 days. A minimum of 20% of the balance is due at the time of service. _____

All Patients

- Please be advised, if you are here for a complete eye exam and have health problems that you want to discuss with your doctor during your visit, this could result in additional charges, or testing. This may or may not be covered by your insurance. You must discuss and clarify the reason for your visit with the technicians and doctor. Please verify if you are here for your routine annual vision exam, as it is our policy to NOT change the diagnosis after your visit – regardless of any medical condition you may have. _____
- Refraction is a test that is performed to measure your best vision possible. This test is performed for several different reasons including (but not limited to): determining the correct prescription for glasses or contact lenses, screening and monitoring of medical conditions, pre-operative care and post-operative care. Federal guidelines require that the eye examination and the refraction are billed separately, but some insurance companies (i.e. Medicare) do not pay for the refraction. Depending on your insurance benefits you may be responsible for payment of this service. The current charge for this is $51.00. _____

Delinquent Accounts

- A statement of your account will be mailed to you at the beginning of each month if an outstanding balance of greater than $5.00 exists. Please watch your insurance EOB's to see if you owe a balance. _____
- Payment in full is expected within 30 days after the insurance company has made a determination of payment, or 90 days from the date of service, whether or not insurance has responded. If circumstances prevent you from paying your account in a timely manner, please contact our billing department to set up payment arrangements. Delinquent accounts are subject to collection processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged by CCS. Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic. _____
- Balances on your account need to be paid in full before you will be seen again, unless a payment arrangement has been made with our billing department. Please contact our billing department in a timely manner, as any claim over 90 days will be due in full. _____
- Wolf Eye Center will charge a $25.00 fee for any returned checks for non-sufficient funds (NSF). _____

I, the undersigned, authorize payment of medical benefits to Wolf Eye Center for any/all service provided to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance plan. I authorize Wolf Eye Center to release information concerning my health care, advice, treatment, and/or supplies to my insurance company and/or it's agents for the purpose of evaluating and administering claims. I understand that if I do not have insurance coverage payment is due in full at time of service unless an approved payment plan has been established.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18) Date