PATIENT REGISTRATION

UDAY DEVGAN, MD, FACS, FRCS

Name _____ Preferred Phone _____

Address _____ City _____ ST _____ Zip _____

Date of Birth ____-____-____ Age ____ SSN _____-____-_____ Preferred email_____

Occupation_____ Referred By _____

Internist / Family Physician _____ Phone _____

Emergency Contact _____ Phone _____

HOW WOULD YOU PREFER WE CONTACT YOU? (appointment reminders) [ ] Call [ ] Text [ ] Email

DO YOU HAVE MEDICAL HEALTH INSURANCE? [ ] Yes [ ] No

If yes, please provide your insurance card to the front desk team.

ACCEPTANCE OF CARE RELATIONSHIP, FINANCIAL RESPONSIBILITY, AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS DIRECTLY TO PROVIDER

I understand I am financially responsible to Uday Devgan, MD, FACS, FRCS and DA Wallace Inc. (dba LA Sight Medical Center or "LA Sight") for all charges incurred as a consequence of medical care received through this office, including any charges not covered by my insurance carrier**. This includes charges for refraction (prescription measurement of the eyes) that may or not be covered by your health insurance policy.**

I hereby authorize the release of any information requested by my insurance carrier concerning my present illness or injury.

I hereby also assign to Dr. Devgan and LA Sight all money to which I am entitled for medical and/or surgical expenses relative to the services reported. I permit a copy of this authorization to remain on file and be used in place of an original signature for claims filed. I request that payment of authorized Medicare benefits be made on my behalf to LA Sight for any services furnished me by or under supervision of its physicians. 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 and process related claims accordingly.

_____ _____

Signature **Date**

Please Turn Over →

MEDICARE LIFETIME SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to D.A. Wallace dba LA Sight Medical Center, PC ("LA Sight") any services furnished me by David A. Wallace, MD and Uday Devgan, MD or the office of LA Sight. 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 that my signature below authorizes that payments be made, and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or any agency shown. In "Medicare-assigned" cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the insurance coverage of the beneficiary and are subject to determination of the Medicare carrier.

REFRACTION FEE

A refraction is the measurement of your optical prescription, for the purpose of determining your best-corrected vision, and provides you with the written prescription necessary to purchase new eyeglasses and/or contact lenses.

If Medicare is your primary insurance, the refraction is not reimbursed as part of the eye examination. This fee is your responsibility, and is collected at the time of your visit. **The refraction fee charged by LA Sight is $75.00.**

OPTION TO LEAVE CREDIT CARD ON FILE

[ ] I would like to leave my credit card on file with LA Sight, and authorize the charge of any residual balance after my insurance has reviewed and paid my claim. I understand an email receipt will be sent after the charge has been processed.

[ ] I decline to leave my credit card on file and ask that a paper statement of any balance due be mailed to me.

_____	_____	_____
Print Name	**Your Signature**	**Date**