

**Chili Vision Group**  
Patient Registration Information Sheet

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Gender:    M    F    Social Security #: \_\_\_\_\_

Marital Status:    \_\_\_\_\_M(Married)    \_\_\_\_\_S(Single)    \_\_\_\_\_W(Widowed)    \_\_\_\_\_D(Divorced)

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Previous Eye Doctor (if new patient): \_\_\_\_\_

Is the patient responsible for the bill?    YES    NO

If NO, please put name of the person responsible: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Insurance Information**

Insurance Company 1: \_\_\_\_\_ Policy #: \_\_\_\_\_  
(Please write number exactly as it appears on the card. Also include any prefix or suffix.)

**Financial Assignment and Agreement:**

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge.  
**It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid by your insurance.**
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release the **Health Care Financing Administration**, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related service.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by all said insurances. I hereby authorize said assignee to release all information necessary to secure the payment.
4. Patient agrees to accept responsibility for any cost related to collecting past due amounts including collection and attorney fees.

Signed (patient - or parent, if minor): \_\_\_\_\_ Date: \_\_\_\_\_

3171 Chili Avenue  
Suite 100  
Rochester, New York 14624

Phone: 585.889.9693  
Fax: 585.889.3558

## Acknowledgement of Receipt and General Consent

I acknowledge that I received a copy of the CHILI VISION GROUP'S Notice of Private Practices.

I further consent to the release of my health information for the purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Louis E. Baskin, O.D.

Pamela J. Brown, O.D.

Emily F. Culliton, O.D.

Allison M. Ford, O.D.

Shruti Pandya, O.D.

Melanie A. Shearer, O.D.

Mark S. Jacobson, M.D.  
*Medical/Surgical Consultant*

Patient Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Source of Authority: \_\_\_\_\_

General and Medical  
Optometry

Contact Lenses

Glaucoma and Diabetes  
Co-Management

Refractive Surgery  
Co-Management

Dry Eye Therapy

Optical