River Falls Eye Surgery and Laser Center
Anthony Novak, MD
138 East Pomeroy Street
River Falls, WI 54022
Phone: 715-425-0115
Fax: 715-425-6001

REGISTRATION FORM

PATIENT INFORMATION

Date: _____

First Name: _____ MI:_____Last Name:_____

Date of Birth: ____/____/____ Age: ____ Sex: Male___ Female___ Other___

Address Street: _____ City: _____ State: _____ Zip: _____
(Primary physical address)

Address Street: _____ City: _____ State: _____ Zip: _____
(Billing address, if different)

Primary phone: (_____) _____

Cell Phone: (_____) _____ May we text you for appointment reminders? Yes No

- ☐ Yes, you may leave a detailed message if I am not available. A detailed message will include personal medical information.
- ☐ No, do not leave any personal information when leaving messages.

E-Mail:_____

Referred by: _____ Walk-in_____ Internet _____

Emergency Contact: _____ Phone# (_____) _____

Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name_____ ID_____ Group _____

Name of policy Holder _____ DOB_____

Secondary Insurance Name _____ ID_____Group_____

Name of Policy Holder _____DOB _____

Co-pay amount $ _____ (Copays are due at the time of service)

_____No Insurance (payment is due today)

_____Is this due to a Work Comp injury? Yes___No___

Please complete and sign back side of form

PATIENT COMMUNICATION

By law, without your authorization, Eye Surgery and Laser Center/Dr. Novak's Office cannot communicate your information with unauthorized persons. Please list below the names of people who we may communicate with regards to your appointments, medical/vision care or account information. You do not need to list Doctors or Primary Care Clinic Personnel.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do NOT wish to allow any of my information to be share with anyone including my spouse, or any other family members, friends, guardian or caregivers.

FINANCIAL ASSIGNMENT and AGREEMENT

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 other balance not paid for by your insurance.

If this visit is for a cosmetic procedure, your payment will be due at the conclusion of each visit.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to 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 services.

I understand my insurance coverage is a relationship between my insurance company and myself and agree to accept financial responsibility for charges incurred, including co-pays, deductibles, or charges that are denied. In the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

I hereby authorize Eye Surgery and Laser Center to release all information necessary to secure payment.

By signing below, I am stating that I have read and I agree to the above information on both sides of this registration form, including financial agreement, demographics and communications.

Date: _____ Signature: _____

By signing below, I am stating that I have read and I still agree with the above information on both sides of this registration form, including the financial agreement, demographics and communications.

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____