Arezo Amirikia M.D., P.C.

Patient Registration

PATIENT INFORMATION

Name _____ Age _____ Date _____
Date of Birth _____ SS# _____ Sex: M F
Phone: Home _____ Work _____ Cell _____
Address _____
City _____ State _____ Zip Code _____
Referred by: _____ Email _____
Primary Care Physician _____ Phone _____
Race / Ethnicity (Circle): African American / Black, American Indian, Asian, Caucasian / White, Native Hawaiian / Pacific Islander or Other

PHARMACY INFORMATION

Please provide any information you may know about your pharmacy (local or mail order).
Name of Pharmacy _____
Cross Roads _____ City _____ State _____ Zip _____
Phone _____ Fax _____
Please Check: ☐ 30day supply ☐ 90day supply

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Home _____ Cell _____ Work _____
Address _____ City _____ State _____ Zip _____

PRIMARY MEDICAL INSURANCE

Please Check: ☐ Medicare ☐ BCBS ☐ Blue Care Network ☐ Priority Health
☐ HAP ☐ PPOM/Cofinity ☐ United Health Care ☐ Military
☐ Self Pay ☐ Other _____
Subscriber Name _____ Relationship to Patient _____
Subscriber SS# _____ Subscriber Birth Date _____ Sex: M ☐ F ☐

SECONDARY MEDICAL INSURANCE

Please Check: ☐ Medicare ☐ BCBS ☐ Blue Care Network ☐ Priority Health
☐ HAP ☐ PPOM/Cofinity ☐ United Health Care ☐ Military
☐ Self Pay ☐ Other _____
Subscriber Name _____ Relationship to Patient _____
Subscriber SS# _____ Subscriber Birth Date _____ Sex: M ☐ F ☐

VISION INSURANCE

Please Check: ☐ BCBS Vision ☐ VSP ☐ Eyemed ☐ Optum Health Vision (Spectera)
☐ NVA ☐ Heritage ☐ Delta Vision ☐ Superior Vision
☐ MEBS ☐ MECA ☐ Other _____

☐ **I do not have any vision insurance. I understand that I will be financially responsible on the day of service for any vision services/products received. Please initial _____**

Subscriber Name _____ Relationship to Patient _____
Subscriber SS# _____ Subscriber Birth Date _____ Sex: M ☐ F ☐

WORKERS COMPENSATION (Please Complete if Applicable)

Date of Injury _____
Business Name _____ Business Phone _____
Business Address _____ City _____ State _____ Zip _____

AUTHORIZATION TO DISCUSS MY MEDICAL RECORDS

Please list any person(s) you wish to permit access to your protected medical information.
I authorize _____,
relationship to me _____, to discuss my medical condition with Dr. Arezo Amirikia or or their designee and to obtain any test results on my behalf.

AUTHORIZATION FOR TREATMENT AND BILLING

I hereby authorize Arezo Amirikia, M.D., P.C., and its physicians, to treat me (or my dependent/child) and to release any medical information required by my insurance carrier. If Arezo Amirikia, M.D., P.C. and its physicians participate with my insurance carrier, I authorize and request my insurance carrier to pay directly to Arezo Amirikia, M.D., P.C. for medical, surgical, or vision services rendered, not to exceed the reasonable and customary charges. I understand that I am financially responsible for charges not covered, authorized or paid by my insurance.

I understand that balances not paid by my insurance carrier after **90 days** may become my responsibility. Patient balances over 90 days will be assessed a monthly finance fee of **4%** if arrangements have not been made with the billing department.

Accounts turned over to collections will be assessed a processing fee of **$50.00**
Any changes needed in my optical order **due to medical necessity** must be performed within 30 days of receipt

I understand that I must give 24-hour notice when cancelling or rescheduling an appointment. Failure to do so will result in a **$50.00** fee.

All returned checks will be assessed as $**40.00** fee.

A fee of **$25.00** will be assessed for any patient electing to obtain their PD (Pupillary Distance) measurement as this is not part of your eye exam.

I have received a copy of the Arezo Amirikia, M.D., P.C. Notice of Privacy Practices for Protected Health Information.

Print Name _____

Patient Signature _____

Date _____

REVISED 8/26/22