

Kristin J. Tarbet, MD
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1810 116th Ave NE Suite D1
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PATIENT REGISTRATION

Date _____

Name (Last, First, Middle Initial) _____

Person Responsible for Bill (If Not Patient) & Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Gender (circle one) M F Social Security Number _____

Patient Employer _____ Work Phone _____

Marital Status _____ Spouse's Name (Parent if minor) _____

Primary Care Physician / Phone # _____

Eye Physician / Phone # _____

Whom may we thank for referring you? _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Insurance Name _____ Subscriber Name _____

Subscriber Birth date _____ Subscriber SS# _____

Relation to Subscriber (child, spouse, self, other) _____ Member ID / Policy Number _____

Group Number _____ Effective Date _____ Copayment Amount _____

Secondary Insurance Name _____ Subscriber Name _____

Member ID/Policy Number _____ Group Number _____

Effective Date _____ Copayment Amount _____

I understand that I am financially responsible for all charges whether or not paid by insurance. Insurance coverage is NOT a guarantee of payment for services provided by my healthcare provider including preventive, routine screening, vaccinations or procedures considered cosmetic in nature. **It is my responsibility to understand my insurance benefits.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance. **Co-payment amounts mandated by my insurance company may not be printed on my insurance card. I understand that co-payments are due at the time of service.** It is my responsibility to notify the receptionist upon arrival that a co-payment is due. A \$20.00 handling fee will be added to my statement in circumstances when I have not paid my co-payment at the time of service. I have been informed that NSF's for checks or credit card payments are subject to a \$25.00 fee for each submission. **A NO SHOW appointment without 24 hours advance notice is subject to a \$40.00 fee.** I have been informed that payment is due upon the receipt of my monthly statement. **Should I have NO insurance I understand that payment is due in full at the time of service.**

Patient/Guardian Signature _____ Date _____