Email

Save

Print

Kristin J. Tarbet, MD
Oculofacial Plastic, Cosmetic and Reconstructive Surgery
1810 116th Ave NE Suite D1
Bellevue, WA 98004

Note: If you are using an internet email such as Yahoo or GMail, you will first need to SAVE your form. You will then need to send the saved form as an email attachment via your email client.

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** (select 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** _____