AGGARWAL EYE CARE

Operated by Aggarwal Ophthalmology LLC

PATIENT REGISTRATION AND FINANCIAL ACKNOWLEDGMENT

PATIENT INFORMATION

Legal name: _____	Preferred name: _____
Date of birth: ____ / ____ / _____	Pronouns (optional): _____
Address: _____	City / State / ZIP: _____
Mobile phone: _____	Home / other phone: _____
Email: _____	Preferred contact: Phone / Text / Email
Primary care physician: _____	Phone: _____
Referring physician: _____	Phone: _____
Pharmacy: _____	Phone: _____

INSURANCE INFORMATION

Primary insurer: _____	Member ID: _____
Subscriber name: _____	Relationship: _____
Group number: _____	Referral required? Yes / No / Unsure
Secondary insurer: _____	Member ID: _____
Subscriber name: _____	Relationship: _____

For security and identity-theft prevention, this form does not request a Social Security number. The practice will request only information reasonably necessary for treatment, billing, and insurance processing.

EMERGENCY CONTACT

Name: _____	Relationship: _____
Primary phone: _____	Alternate phone: _____

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Payment: Copayments, deductibles, coinsurance, and non-covered services are due as communicated by the practice. Please contact us before service if you need to discuss payment arrangements.

Insurance: Insurance verification is not a guarantee of coverage or payment. You are responsible for providing current insurance information and required referrals or authorizations.

Assignment and authorization: I authorize payment of applicable insurance benefits directly to Aggarwal Ophthalmology LLC for services provided. I authorize the practice to disclose information reasonably necessary for treatment, payment, healthcare operations, and claim administration as permitted by law.

Patient responsibility: I understand that I am responsible for amounts lawfully due after insurance processing, subject to applicable contracts and law. The practice will not impose interest or collection charges except as separately disclosed in writing and permitted by applicable law.

Returned payments: Any returned-payment charge will not exceed the amount permitted by Michigan law and will be disclosed before collection.

I have read and understand the financial policy and assignment above.

Patient/authorized representative signature: _____	Date: ____ / ____ / _____
Printed name: _____	Relationship (if applicable): _____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

I acknowledge that I was offered or received Aggarwal Ophthalmology LLC's Notice of Privacy Practices, which explains how health information may be used or disclosed and how I may exercise my privacy rights.

I understand that this acknowledgment is not an authorization for uses or disclosures that require a separate authorization, is not a waiver of my privacy rights, and is not a condition that limits emergency treatment.

I may request restrictions or confidential communications. The practice is not required to agree to every requested restriction, except where applicable law requires otherwise. I may obtain a current copy of the Notice from the office and may contact the Privacy Officer with questions or complaints.

Patient/authorized representative signature: _____	Date: ____ / ____ / _____
Printed name: _____	Relationship (if applicable): _____

OFFICE USE ONLY - If acknowledgment was not obtained:

Reason: Patient declined / Emergency / Communication barrier / Other: _____	Staff initials: _____ Date: _____