Eye Centers of America, LLC

PATIENT REGISTRATION FORM

First Name MI **Last Name**		**Suffix**	**Sex: M / F**
Home Address		**Date of Birth**	
City	**State**	**Zip Code**	
Preferred Language	Race ☐ Native American (Indian) ☐ Black/African American ☐ Asian		
Ethnicity ☐ Hispanic Origin. ☐ Not of Hispanic Origin	☐ Native Hawaiian/Pacific Islander ☐ Hispanic or Latino ☐ White		
Home #	Work #	Cell #	
Social Security #	Marital Status ☐ S ☐ M ☐ D ☐ W	E-mail	
Patients' Employer Name, Address / Occupation			
Emergency Contact Name	Phone #	Relationship	
Referring Physician/	Phone #	City	
Primary Care Physician	Phone #	City	
Financially responsible person (if different from patient)			
Responsible person's address:		Phone #	
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?		☐ Yes ☐ No	
Is this visit related to an automobile accident or Workers' Compensation?		☐ Yes ☐ No	

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Vision Insurance:			

FINANCIAL POLICY STATEMENT

Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept the assignment. All co-pays, co-insurance, and deductibles are due and payable at the time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services being the sole responsibility of the patient/responsible party. You will be responsible for any balances not covered by your insurance. A return check fee of $36.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, the patient will be charged a $25.00 fee. For the second occurrence, the patient will be charged a $35 fee. For the third occurrence, the patient will be charged a $50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no-show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

HIPAA - This office will comply with all aspects as printed in our Notice of Privacy Practice, and our privacy notice will be in compliance with all appropriate laws and regulations.

PATIENT AUTHORIZATION

I hereby authorize Eye Centers of America, LLC to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and/or any other insurance company be made directly to Eye Centers of America, LLC. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above-named carrier or in the case of Medicare Part B benefits. I agree to allow Eye Centers of America to file an appeal on my behalf with my health plan.

I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature_____ Date _____

Eye Centers of America, LLC

HIPAA NOTICE OF PRIVACY PRACTICE

Privacy Consent

I understand that Eye Centers of America, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy. I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Eye Centers of America, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Eye Centers of America, LLC has already made in reliance prior to my consent. Eye Centers of America, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

I acknowledge that by signing this form, I permit Eye Centers of America, LLC, to release any information to the physician(s) involved in my care. I consent that Eye Centers of America, LLC, may call my house or designated locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Eye Centers of America LLC may mail to my home appointment reminders and patient statements.

I designate the following representative(s) as being legally authorized to communicate with Eye Centers of America, LLC, on my behalf. If you do not designate anyone below, the Doctor/Eye Centers of America, LLC, will not be able to speak with anyone besides the patient regarding your medical condition.

I acknowledge and give my consent to Eye Centers of America, LLC, to use the standard of care images taken of my eyes. These images will be used for submission to a 3rd. party imaging vendor for certification purposes only. All personal identifiers will be removed prior to images being used.

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Signature

Patient Name:_____Date of Birth: _____

Signature (Patient or Legal Guardian): _____Date: _____

PLEASE INFORM THE DOCTOR OF ALL PHYSICIANS YOU ARE CURRENTLY SEEING

SPECIALTY	PHYSICIAN NAME	ADDRESS	PHONE NUMBER
Ophthalmologist			
Optometrist			
Internist			
Endocrinologist			
Cardiologist			
Nephrologist			
Neurologist			
Podiatrist			
Other			

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone# _____