Eye Physicians inc.

PATIENT REGISTRATION PACKET

Please Print clearly and Fill in all Areas on all 4 Pages	❑ New Patient ❑ Existing/Update

PATIENT INFORMATION

First name:	Last:	M.I.	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Family Doctor:
Social Security #: / /	Date of Birth: / /	Sex: ❑ M ❑ F	Student: *(circle one)* Yes or No *(circle one)* Part-Time or Full-Time	
Home address:		City:	State:	Zip Code:
Please list contact number (to the right) in the order we should call you.	Primary Phone #: (*This # will be used for appt reminders)* ( ) Home Cell Work		Secondary Phone #: ( ) Home Cell Work	
Marital status *(circle one)* Single Married Divorce Widow	Employer:	Full-Time or Part-Time	Employer Phone #: ( )	

E-mail Address: *(For communication/reminders and/or Portal Set Up)* _____

RESPONSIBLE PARTY INFORMATION

(If patient is child, who do they reside with)

Full Name:	Phone #:	Relationship to patient: ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Step-Father ❑ Step-Mother ❑ Other	
Mailing Address:	City:	State:	Zip Code:

Is this patient covered by insurance? ❑ Yes ❑ No *(If yes, proceed to next section)*

INSURANCE INFORMATION

(Please give your insurance card and a picture ID to the receptionist)

PRIMARY Insurance Policy Holder: ❑ Patient ❑ Father ❑ Mother ❑Step-Father ❑ Step-Mother ❑ Other

Name of Primary Insurance Company:

Policy Holder's Full Name:		Policy Holder's Social Security #: / /	Policy Holder's Date of Birth: / /
ID #:	Group #:	Employer:	Employer Phone #: ( )

SECONDARY Insurance Policy Holder: ❑ Patient ❑ Father ❑ Mother ❑Step-Father ❑ Step-Mother ❑ Other

Name of Secondary Insurance Company:

Policy Holder's Full Name:		Policy Holder's Social Security #: / /	Policy Holder's Date of Birth: / /
ID #:	Group #:	Employer:	Employer Phone Number: ( )

VISION INSURANCE Policy Holder: ❑ Patient ❑ Father ❑ Mother ❑Step-Father ❑ Step-Mother ❑ Other

Name of Vision Insurance Company:

Policy Holder's First Name:		Policy Holder's Social Security # / /	Policy Holder's Date of Birth: / /
ID #:	Group #:	Employer:	Employer Phone Number:

My signature confirms that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration.

_____ *(Printed Name)*

_____ *(Signature)*

_____ *(Date)*

Notice of Privacy Practices/ Phone Message/ Contact Authorization

Patient Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICE

The **Notice of Privacy Practice (NPP)** tells you how we may use and share your medical records. It also describes your rights with respect to your medical records. **Please read it.**

- We will use and share your health records to treat you and bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

I understand that the NPP is available on the Eye Physicians Inc website (www.eyephysiciansinc.com) and at my physician's office. **I acknowledge receipt of the Eye Physicians Inc Notice of Privacy Practices (NPP).**

Signature of Patient: _____ **Date:** _____

Signature of Authorized Representative: _____ **Date:** _____

Name of Authorized Representative: _____ **Date:** _____

PHONE MESSAGE AND CONTACT AUTHORIZATION:

Please CHECK the appropriate answer below:

Do the providers and staff of Eye Physicians Inc have your permission to leave messages containing medical and/or financial information on your answering machine/voice mail?

At home	_____ Yes	_____ No *	Phone # _____
At work	_____ Yes	_____ No *	Phone # _____

*IF YOU CHECK "NO", THE DATE, TIME AND LOCATION OF APPOINTMENTS WILL BE THE ONLY INFORMATION LEFT ON YOUR ANSWERING MACHINE/VOICE MAIL.

The individual(s) named below will also be your emergency contact(s) unless you specify otherwise.
Please complete below: I give authorization to the providers and staff of Eye Physicians Inc to discuss my medical and/or financial with the following people- **If you do not provide this information Eye Physicians Inc will not be able to discuss your health records with spouse, children etc..**

	Name	Relationship	Phone #
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____

I understand it is my responsibility to inform Eye Physicians Inc of any desired changes in this authorization.

Signature: _____ **Date:** _____

PATIENT FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

FINANCIAL AGREEMENT
I agree that payment in full is due at the time of treatment. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. Eye Physicians Inc. will file for insurance benefits and accept payments per Eye Physicians Inc contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by Eye Physicians Inc is given strictly as a courtesy and implies no responsibility on Eye Physicians Inc's part for filing, follow through or confirmation. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered.

RETURNED CHECK FEE
I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services.

PAST DUE ACCOUNTS
If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize Eye Physicians Inc to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating and I may be discharged from Eye Physicians Inc.

PAYMENTS
We accept cash, debit cards, Visa, MasterCard, American Express, personal checks and money orders. Any outstanding balances are due within 30 days of the statement.

AUTO ACCIDENTS
Payment for all services is due at the time of service. Receipts will be given for you to seek reimbursement.

TREATMENT OF MINORS/DIVORCE DECREES
If the patient is a minor, the parent or guardian must sign below. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any bills, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility.

REFERRALS AND AUTHORIZATIONS
If I have an insurance plan that requires any referrals, pre-certifications or authorizations I understand that it is my responsibility and not Eye Physicians Inc to obtain approval from my insurance plan for medical services and/or procedures prior to such medical services and/or procedures being rendered. Some insurance companies may take up to 48 hours or more to obtain a referral. Additionally, if any aforementioned procedures are not done and medical services and/or procedures are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for the claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform Eye Physicians Inc immediately of any change in insurance coverage and/or benefits and change of personal information. I understand medical services may not be rendered without the proper referral on file.

LAB WORK
Many insurance companies require a specific laboratory be utilized. If your policy requires a laboratory, please inform the technician staff at each visit.

Consent for Treatment

CONSENT FOR TREATMENT
I request and give consent to my medical provider to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my provider for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

I have read, understand and agree to comply with these policies.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Authorized Representative Relationship to Patient Date

AUTHORIZATION AND ASSIGNMENT

Patient Name: _____ Date of Birth: _____

CERTIFICATION

I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and understand and fully accept the terms therein.

INSURANCE PARTICIPATION

Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. However, there are several points we would like to mention:

- Your policy is a contract between you and the insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have questions.
- You must bring your insurance card with you to every visit, and make us aware of any changes in coverage.
- You are expected to pay your co-payment at each visit when you check in.
- If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be aware of your coverage and be prepared.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize Eye Physicians Inc to apply for benefits for services rendered to myself or minor child(ren) under Medicaid, Medicare, or any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to Eye Physicians Inc (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to Eye Physicians Inc. I authorize Eye Physicians Inc to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION

I authorize Eye Physicians Inc to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare & Medicaid Services CMS, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Eye Physicians Inc; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to Eye Physicians Inc as required for payment of benefits and/or required for medical or any other reasons; and authorize Eye Physicians Inc to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied. Patients requesting a permanent transfer of records or copies for personal reasons may incur a charge. Record Copy Fee: Minimum charge is $10.00 or $1.00 per page for 1st 10 pages, $0.50 per page for pages 11-50, and $0.25 for each page in excess of 50.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

I understand that Eye Physicians Inc agrees to bill my health insurance carrier as a courtesy to me. I must submit information as needed by my insurance carrier or Eye Physicians Inc to guarantee payment for services rendered to me. I understand I am ultimately responsible for payment of all services.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Authorized Representative Relationship to Patient Date

REVIEW OF SYSTEMS

NAME: _____ DATE: _____ FAMILY DOCTOR: _____

MEDICAL HISTORY

Please indicate any diagnosed condition by checking YES or NO:

Eyes	**YES**	**NO**
Loss of vision	___	___
Blurred vision	___	___
Halos/glare (Daytime/night)	___	___
Pain/soreness/burning/ Itching/dryness	___	___
Double vision	___	___
Vision fluctuation	___	___
Endocrine		
Thyroid	___	___
Diabetes	___	___
Cardiac		
High Cholesterol	___	___
High blood pressure	___	___
Pacemaker	___	___
Arrhythmia	___	___
Coronary artery disease/ Stents	___	___
Respiratory		
COPD	___	___
Asthma	___	___
Ears/Nose/Throat		
Sinus congestion	___	___
Dry mouth	___	___
Hematologic/Lymphatic		
Bleeding disorder	___	___

Immunologic/ Infection	**YES**	**NO**
Hepatitis	___	___
HIV/AIDS	___	___
Tuberculosis	___	___
Latex allergy	___	___
Seasonal/all year Allergies	___	___
Neurologic		
Stroke/seizure/TIA	___	___
Migraine/headache	___	___
Psychiatric		
Depression	___	___
Anxiety	___	___
Bipolar/schizophrenia	___	___
Gastrointestinal		
Heartburn/ulcers/ GERD	___	___
Liver/intestine	___	___
Constitutional		
Fever	___	___
Unexplained weight Loss	___	___
Skin and/or breast		
Rashes	___	___
Mass	___	___

Cancer	**YES**	**NO**
	___	___
Type _____		
Rheumatologic		
Rheumatoid arthritis	___	___
Fibromyalgia	___	___
Musculoskeletal/ Osteo arthritis/ Osteopenia	___	___
Bladder	___	___
Kidney	___	___
Genital	___	___
Prostate	___	___
Women		
Pregnant	___	___
Trying to get pregnant	___	___
Nursing	___	___

Other _____
_____
_____

SURGERIES

Date Type

_____
_____
_____
_____

SOCIAL HISTORY

Job Title/Occupation _____: or

	YES	**NO**
Retired	___	___
Disabled	___	___

	YES	**NO**
Alcohol	___	___
Tobacco products	___	___

(Over)

CURRENT MEDICATIONS/SUPPLEMENTS/DOSAGE
(We can make a copy of your list)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

EYE MEDICATIONS

_____	_____
_____	_____

MEDICATION ALLERGIES	**REACTIONS**
_____	_____
_____	_____

FAMILY HISTORY	**YES**	**NO**	**MOTHER**	**FATHER**	**SIBLING**
Glaucoma	___	___	_____	_____	_____
Macular Degeneration	___	___	_____	_____	_____
Cataract	___	___	_____	_____	_____
Retinal Detachment	___	___	_____	_____	_____
Diabetes	___	___	_____	_____	_____
Anesthesia complication	___	___	_____	_____	_____
Heart attack	___	___	_____	_____	_____
High blood pressure	___	___	_____	_____	_____
Stroke	___	___	_____	_____	_____

Other _____

PHARMACY INFORMATION

Local Pharmacy You Use: ***(Include Location)*** _____
Mail Order Pharmacy: ***(Optional)*** _____

MEANINGFUL USE CRITERIA To be able to fulfill the Meaningful Use criteria please provide the information below	
Race *(select at least one)* ❑ White ❑ African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Refuse to Report	
Ethnicity *(Please select only one)* ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Refuse to Report	
Language Best Served:	**Veteran:** *(circle one)* Yes or No