Patient Registration The Heyde Eye Center

Patient Information (PRINT CLEARLY)- Please provide a Photo ID			
LAST NAME:	FIRST NAME:		M.I.:
PREFERRED NAME:	SEX (Circle one): MALE or FEMALE		DATE OF BIRTH:
MARITAL STATUS (Circle One): SINGLE MARRIED WIDOWED DIVORCED			SOCIAL SEC. NO.:
STREET ADDRESS:	CITY:	STATE:	ZIP:
COUNTY:	EMAIL ADDRESS:		
HOME PHONE:	CELL PHONE:		
EMPLOYER:	EMPLOYER PHONE:		
Primary (Please Circle): Home Phone Cell Phone Email Secondary (Please Circle): Home Phone Cell Phone Email	We will refer to the information in the above section for your preferred method of communication. No medical information will Be left on a message or an email without your permission. You will be asked to contact the office for further information.		
PHARMACY NAME:	CITY:	PHONE:	
NAME OF MEDICAL DOCTOR:		PHONE:	
EMERGENCY CONTACT PERSON:		DATE OF BIRTH:	
PHONE NO.:	RELATIONSHIP TO PATIENT:		
NAME OF RESPONSIBLE PARTY:			
RELATIONSHIP TO PATIENT:	DOB:	SSN:	
STREET ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PRIMARY PHONE:	ALTERNATE PHONE:		
EMPLOYER:	EMPLOYER PHONE:		

PRIMARY INSURANCE (present all card(s) to front desk for copying)		
INSURANCE COMPANY:		
INSURANCE ID NUMBER:	GROUP NO.:	POLICY EFFECTIVE DATE:
NAME OF INSURED (AS IT APPEARS ON CARD):		
INSURED'S DATE OF BIRTH:	INSURED'S SSN:	
RELATIONSHIP OF PATIENT TO INSURED (Circle One): SELF SPOUSE CHILD OTHER_____		

SECONDARY INSURANCE (if applicable)		
INSURANCE COMPANY:		
INSURANCE ID NUMBER:	GROUP NUMBER:	POLICY EFFECTIVE DATE:
NAME OF INSURED (AS IT APPEARS ON CARD):		
INSURED'S DATE OF BIRTH:	INSURED'S SSN:	
RELATIONSHIP OF PATIENT TO INSURED (Circle One): SELF SPOUSE CHILD OTHER_____		

VISION/GLASSES/ROUTINE INSURANCE INFORMATION		
Circle one: **EYEMED VSP DAVIS VISION VCP US SAFETY OTHER:**		
INSURED'D NAME:	**INSURED'S DATE OF BIRTH:**	**SSN:**

Insurance Authorization / Release

I hereby authorize the physician / provider to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any and all services rendered.

In order to comply with your insurance **all co-payments, co-insurance, deductible and/or non-covered services must be paid at the time service is rendered**. I understand that a refraction is usually required for a routine eye exam and that refractions are a noncovered service by Medicare and most commercial insurance companies. I will be responsible for refraction charges. I understand it is my responsibility for obtaining a referral if one is required by my insurance carrier.

I, the undersigned, understand that if I fail to pay my entire bill within 30 days of the initial billing statement and in the case of default on payment of this account, I agree to be responsible for collection costs which are typically 1/3 to 1/2 of the unpaid balance including interest, service charges, court costs and attorney fees. All returned checks will be charged a $25.00 service fee.

Health Insurance Portability and Accountability Act (HIPPA):

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law, including photo I.D verification of identity. It also describes your rights to access and control your protected health information (PHI). We are required to abide by the terms of this Notice of Privacy Practices. I understand I have the right to review the Company's Notice of Privacy Practices (the Notice) and Identity Compliance Program prior to signing this document.

Patient name: _____ Date: _____

Signature: _____ [ ] Parent [ ] Guardian

HIPAA Consent to Disclose Protected Health Information to my Family/Friends

It is the policy of The Heyde Eye Center that the use and disclosure of protected health information (PHI) will be limited and protected as describe by federal, state, and local laws; including HIPAA.

While I am a patient, I do hereby authorize: _____ my
(Name)
_____ to receive protected health information (PHI) about me.
(Realtionship)

By signing this form, I am consenting to allow The Heyde Eye Center to give out information about my condition, treatment, and/or payment to the above named persons. I realize that I may rescind this authorization at any time and will be requested to state this change in writing.

_____ _____
Patient/Parent/Guardian Signature Date