FAMILY EYECARE AT WESTCHASE

PATIENT REGISTRATION FORM

Patient's Name: _____
(Please print clearly)

Guardian/Parent:_____
(If a minor please provide Guardian Name)

Mailing Address: _____

_____

_____
(City) (State) (Zip)

Occupation: _____

Employer:_____

If Student, Grade: _____ **School:** _____

Pharmacy: _____

Pharmacy Phone:_____

Primary Care Physician:_____

Primary Care Physician Phone: _____

Communication Pref.: ❑ Phone ❑ Cell Phone ❑ Text ❑ Mail

❑ E-mail:_____

Date: _____ ❑ **M** ❑ **F**

Age: _____ **Date of Birth:** _____

Home Tel. #:_____

Work Tel. #: _____

Cell Phone #: _____

Patient's Social Security #: _____

Marital Status: ❑ Married ❑ Single ❑ Widow ❑ Divorced

Race: ❑ African American/Black
❑ American Indian or Alaska Native
❑ Asian
❑ Native Hawaiian or Other Pacific Islander
❑ White

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Declined

Other Family Members treated here:_____

_____

Are you interested in information on LASIK? ❑ Yes ❑ No

Whom may we thank for referring you: _____

_____

Allergies: _____

_____

_____

_____

_____

_____

Medications: _____

_____

_____

_____

_____

_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Policy #: _____ **Group #:** _____

Policy Holder's Name:_____ **Date of Birth:** _____

Policy Holder's SS#: _____ **Relationship to patient:** _____

Secondary Insurance Carrier: _____

Policy #: _____ **Group #:** _____

Policy Holder's Name:_____ **Date of Birth:** _____

Policy Holder's SS#: _____ **Relationship to patient:** _____

ASSIGNMENT OF BENEFITS / HIPAA

I request that payment of authorized insurance benefits be made on my behalf to Family EyeCare at Westchase for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization of any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Patient/Guardian Signature _____ **Date** _____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient/Guardian Signature _____ **Date** _____