COMPLETE PRIMARY
EYECARE

PATIENT REGISTRATION FORM

Please present insurance card and photo ID upon registration. Please print the information below:

LAST NAME: _____ FIRST NAME: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: H _____ W_____ CELL _____

EMAIL: _____ MARITAL STATUS: M D W S

SS#: _____ BIRTHDATE: _____ AGE: _____ MALE / FEMALE

FAMILY DR: _____ PHONE: _____

REFERRING DOCTOR: _____ PHONE: _____

PREFERRED PHARMACY: _____

EMERGENCY CONTACT: _____ PHONE: _____

PARENT/GUARDIAN: _____ SS#: _____ DOB: _____

PAYMENT: IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE OR IF YOU HAVE NOT PRESENTED THE CORRECT INSURANCE CARD, SOCIAL SECURITY NUMBER AND DRIVER'S LICENSE, YOU AGREE TO PAY THE FACILITY'S REGULAR RATES IN FULL AT THE TIME OF SERVICE. IF WE PARTICIPATE WITH YOUR PLAN, COPAYS AND DEDUCTIBLES MUST BE PAID AT THE TIME OF SERVICE AND YOUR PRIMARY INSURANCE WILL BE BILLED. YOU ARE RESPONSIBLE FOR BILLING ANY SECONDARY INSURANCES YOU HAVE AND YOU ARE RESPONSIBLE FOR ANY ADDITIONAL MONIES OWED AFTER WE RECEIVE YOUR INSURANCE COMPANY'S PAYMENT (IE: NON-COVERED SERVICES). OUR PROFESSIONAL SERVICES ARE RENDERED FOR AND CHARGED DIRECTLY TO YOU NOT YOUR INSURANCE COMPANY AND YOU AGREE TO BE RESPONSIBLE FOR PAYMENT. PAYMENT MAY BE MADE BY CASH, CHECK OR CREDIT CARD. IF WE ARE NOT A PARTICIPATING PROVIDER, A RECEIPT WILL BE GIVEN TO YOU SUITABLE FOR YOU TO SUBMIT TO YOUR INSURANCE CARRIER. YOU AGREE THAT COSMETIC AND OR NON-COVERED SERVICES WILL NOT BE BILLED TO YOUR INSURANCE AND THAT YOU ARE RESPONSIBLE FOR PAYMENT IN FULL BEFORE OR AT THE TIME OF SERVICE. OUTSIDE SERVICES SUCH AS LABORATORY SERVICES, RADIOLOGY SERVICES AND ANESTHESIA WILL BE BILLED TO YOU DIRECTLY.

SIGNATURE ON FILE: I, THE UNDERSIGNED, REQUEST THAT PAYMENT OF INSURANCE/MEDICARE BENEFITS BE MADE ON MY BEHALF TO COMPLETE PRIMARY EYECARE, FOR ANY SERVICES RENDERED TO ME BY THIS PRACTICE AND ITS PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY HEALTH INSURANCE COMPANY OR THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THOSE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I ACKNOWLEDGE RECEIPT OF A COPY OF THIS OFFICE'S NOTICE OF PRIVACY AND PAYMENT POLICIES. I CONSENT TO EXAMINATION AND TREATMENT, AND I AGREE TO BE FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP (IF OTHER THAN PATIENT): _____ DATE: _____

COMPLETE PRIMARY EYECARE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. THE NOTICE CONTAINS A PATIENT RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. YOU HAVE THE RIGHT TO RECEIVE A COPY OF OUR NOTICE BEFORE SIGNING THE ACKNOWLEDGMENT.THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE HAD THE OPPORTUNITY TO RECEIVE OUR NOTICE OF PRIVACY PRACTICES.

THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENTS, PAYMENTS OR HEALTH CARE OPERATIONS.
- THE PRACTICE RESERVES THE RIGHT TO CHANGE THE NOTICE OF PRIVACY PRACTICES
- I HAVE THE RIGHT TO REQUEST RESTRICTIONS TO THE USES OF MY INFORMATION.THE PRACTICE DOES NOT HAVE TO AGREE TO THOSE RESTRICTIONS, BUT IF WE DO, WE WILL HONOR THESE RESTRICTIONS.

I AUTHORIZE COMPLETE PRIMARY EYECARE TO DISCLOSE INFORMATION REGARDING MY MEDICAL CONDITION(S)/TREATMENT(S) TO:

PLEASE PRINT ALL THAT APPLY:

SPOUSE: _____

CHILD: _____

ANY OTHER: _____

IUNDERSTAND THAT IF I PROVIDE THE PRACTICE WITH A SECONDARY CONTACT, THE PRACTICE MAY CONTACT THAT PERSON WITH INFORMATION REGARDING MY APPOINTMENTS.

PATIENT SIGNATURE: _____ DATE: _____

REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP TO PATIENT (IF OTHER THAN PATIENT): _____