

(Please Print)

PATIENT INFORMATION

TODAY'S DATE:

EYE COLOR:

RACE:

Patient's last name:

First:

Middle:

Mr.
 Mrs.

Miss
 Ms.

Marital status (circle one)

Single / Mar / Div / Sep / Wid

Is this your legal name?

If not, what is your legal name?

Birth date:

Age:

Sex:

Social Security #

Yes No

M F

Address

City

State & Zip Code

Home Phone

Cell Phone

OK to leave message with detailed information

Leave message with call back number

Occupation:

Employer:

Employer phone no:

How did you hear about us?

Dr.

Insurance Plan

Hospital

Family

Friend

Close to home/work

Yellow Pages

Other

E-Mail Address

Other family members seen here:

RESPONSIBLE PARTY INFORMATION

Person responsible for bill:

Birth date:

Address (if different):

Home phone no.:

INSURANCE INFORMATION

Please indicate primary medical insurance

Any Vision Plan coverage?

Yes
 No

Plan Name:

Subscriber's Birth date:

Subscriber's S.S. no.:

Subscriber's name:

Patient's relationship to subscriber:

Self Spouse Child Other

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):

Subscriber's name:

Subscriber's Birth date:

Patient's relationship to subscriber:

Self Spouse Child Other

Primary Care Provider: (doctor's name)

BACK SIDE

**ACCESS EYE CENTERS
REGISTRATION FORM**

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Access Eye Centers for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ **Initial**

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Practice Name for Access Eye Centers any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that it is my responsibility to obtain a referral if it is required by my insurance company. I will be responsible for all charges if I am seen without a referral. **Payment Information**

All payments are due at the time of service. If the account has to be turned over to an attorney/collection agency, the undersigned agrees to pay all cost of collections, including attorney fees, interest, and court cost. This form will be placed in your chart and be applicable until such information is changed.

_____ **Initial**

Use and Disclosure of Protected Health Information

I understand that Access Eye Centers may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 371-2020. I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

_____ **Initial**

REFRACTION POLICY

A refraction is the process of determining if there is a need for corrective glasses or contact lenses. It is an essential part of any eye exam and necessary to write a prescription for glasses or contact lenses. Most medical insurance plans, including Medicare, DO NOT COVER refractions or routine eye exams. Medicare allows that we charge separately for that portion of the exam, since it is not a covered service. If you have a separate vision plan that covers routine or annual eye examinations and or glasses, please let us know. If you have any questions regarding our policy, please do not hesitate to ask. You will be refracted and charged the fee if any of the following occurs:

1. If you want new glasses.
2. If your vision has dropped more than 2 lines from the previous visit.
3. If you complain of any vision changes.

_____ **Initial**

I have read, initialed and understood the above information.

Signature: _____ **Date:** _____
Patient or Legal Surrogate Relationship to Patient

Witness: _____ **Date:** _____