PATIENT REGISTRATION

Patient Name				Salutation	
Birthdate		Age		Birth State	
Sex				SS #	
Address					
Address Type				Country	

COMMUNICATION					
Preference					
Home Phone #		Work Phone #		Extension	
Cell Phone #		Carrier			
Email					

INFORMATION			
Plan Type		HIPAA Signed	
Primary Language		Special Needs	
Race		Ethnicity	
Marital Status		Mother's Maiden Name	
Occupation		Employer	

ACCOUNT RESPONSIBLE					
Responsible				Salutation	
Relationship				SS #	
Address					
Home Phone #		Work Phone #		Extension	
Email					

PRIMARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone		PAY %	
Insured		Date of Birth	
Copay			

SECONDARY INSURANCE			
Name		Group Name	

SECONDARY INSURANCE			
ID #		Group #	
Address			
Phone		PAY %	
Insured		Date of Birth	

Signature/Date

Patient:
Date of Birth:

Consent for Medical Treatment and Release of Information

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Family Eye Center, OD PA
2. **Authorization for Release of Information:** Family Eye Center, OD PA may release information from my medical records to any health care provider involved in my care and treatment. Family Eye Center, OD PA may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Family Eye Center, OD PA is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Family Eye Center, OD PA which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Family Eye Center, OD PA, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Family Eye Center, OD PA. I understand that I am responsible for a $30.00 returned check fee in addition to any other associated bank charges.
4. **Pre-authorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Family Eye Center, OD PA charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Family Eye Center, OD PA.
6. **Charge for No Show/Cancellation without 24 hour notice:** I understand that 24 hour notice is required for canceling an appointment, and I will be charged a $25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of Family Eye Center, OD PA's HIPAA Policy.**

_____ _____

Signature of Patient or Legally Responsible Person | Name (Please Print)

_____ _____

Relationship/Reason Why Patient is Unable to Sign | Date