

REGISTRATION FORM

THE HUGHES EYE CENTER

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)	Sex	Date of Birth	Marital Status	Age	Race	Social Security No.
Patient Address	City	State	Zip Code	Patient Phone No. ()		
Patient Employer	Occupation	Patient E-Mail		Patient Cell No. ()		
Employer Address	City	State	Zip Code	Work Phone No. ()		

SPOUSE / GUARDIAN / NEXT OF KIN INFORMATION

Spouse or Guardian (Last, First, Middle Initial)	Date of Birth	Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Parent	Social Security Number
Spouse or Guardian Address	City	State	Zip Code
Spouse or Guardian Employer			Spouse/Guardian Phone No. ()
Spouse or Guardian Employer Address			Spouse/Guardian Cell No. ()
		City	State
		Zip Code	

BILLING INFORMATION / INSURED

Insured Name (Last, First, Middle Initial)	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dep Child <input type="checkbox"/> Student <input type="checkbox"/> Other	Insured SS Number
Insured Address	City	State
		Zip Code
Insured Employer		Insured Phone No. ()
		Department
Insured Employer Address		Work Phone No. ()
		City
		State
		Zip Code

INSURANCE INFORMATION

Primary Insurance Company			Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Primary Insured Name	Group Number	Policy #, ID #, or Certificate #	Date of Birth		
Secondary Insurance Company			Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Secondary Insured Name	Group Number	Policy #, ID #, or Certificate #	Date of Birth		
Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number	State	Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid Number	State
Is this visit related to an accident? <input type="checkbox"/> Auto <input type="checkbox"/> Job Related			Date of Injury		
Referring Doctor Name		City	State		
Medical Doctor Name		City	State		
Who may we notify in case of an emergency? (Not in same household)			Relationship	Phone Number	

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FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your eye care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must sign prior to any medical evaluation or treatment. All patients must also complete the patient registration form before seeing the doctor.

1. Each patient is responsible for his/her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time medical services are rendered. If co-payment is not paid at time of service patients will be responsible for a \$15.00 billing fee in addition to the co-payment.
3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible, you will need to make payment arrangements with the billing office prior to any medical evaluation or treatment. We accept cash, checks and major credit cards.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. A \$20.00 fee will be charged on all returned checks.

By signing below, I acknowledge receipt of this Financial Policy and Agreement

X _____ Date _____
Signature of Patient or Responsible Party

AUTHORIZATION TO PAY BENEFITS

I authorize and direct said agency or insurance company to pay, benefits or insurance payments in my case, directly to the Hughes Eye Center for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

X _____ Date _____
Signature of Patient or Responsible Party

NOTICE OF PRIVACY PRACTICES / RED FLAGS RULE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you in the process of providing treatment, seeking payment or carrying out our own health care operations. This notice contains a Patient Rights section describing your rights under the law. A copy of the current notice in effect will be posted. Each time you receive treatment or healthcare services you may request a copy of the current notice.

Our Red Flags Rule Compliance Policies and Procedures provide information on safeguards in place to reasonably ensure protected health information and sensitive information related to identity theft.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

X _____ Date _____
Signature of Patient or Responsible Party

BREACH NOTIFICATION ACT

Under the HITECH Act passed in 2009, The Hughes Eye Center will comply with the Breach Notification Rule. Patients will be notified of specified breaches of unsecured protected health information. This notification will occur in a timely manner and no less than 60 days from the date of the breach.

X _____ Date _____
Signature of Patient or Responsible Party