TEXARKANA EYE ASSOCIATES

PATIENT REGISTRATION FORM

Today's Date:	**How did you hear about our office?** (circle one) □ Newspaper □ TV □ Billboard □ Friend □ Other _____
Communication Preference (circle one): Email Postal Telephone	

PATIENT INFORMATION

Last Name:	**First:**	**Middle:**	□ Mr. □ Ms. □ Mrs. □ Miss.
SSN:	**Date of Birth:**	**Sex:** □ **M** □ **F**	**Marital Status:** □ Single □ Married □ Divorced □ Separated

Race: □ American Indian/Native Eskimo □ Asian □ African American □ Hispanic □ Caucasian □ Native Hawaiian/Other Pacific Islander

Address:	**City:**	**State:**	**Zip:**
Home #:	**Cell:**	**Email:**	
Occupation:	**Employer:**	**Employer Phone:**	
Guardian (if minor):	**Relation:**	**Signature of Guardian:**	

EMERGENCY CONTACT INFORMATION

Name:		**Relationship to Patient:**
Home #:	**Cell #:**	**Work #:**

INSURANCE INFORMATION

(Please fill section out completely and give insurance cards to receptionist)

Vision Insurance Company:	**Policy Number:**	**Group Number:**
Subscriber's Name:	**Subscriber's SSN:**	**Subscriber's DOB:**
Relationship to Patient: □ Self □ Spouse □ Dependent □ Other _____	**Patient Name:**	
Medical Insurance Company:	**Policy Number:**	**Group Number:**
Subscriber's Name:	**Subscriber's SSN:**	**Subscriber's DOB:**
Relationship to Patient: □ Self □ Spouse □ Dependent □ Other _____	**Patient Name:**	

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance and assign directly to Texark otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I her necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:	**Relationship to Patient:**

MEDICARE AUHTORIZATION

I request that the payment of authorized Medicare benefits be made either to me or on my behalf to Texarkana Eye Associates for any services furnished to me by that clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 0 or the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and

the deductible are based upon the charge determination of the Medicare carrier.	
Signature of Beneficiary:	**Medicare Number:**

FINANCIAL LIABILITY

Thank you for choosing Texarkana Eye Associates for your eyecare needs. We are happy to serve you, and look forward to a long relationship with you, our valued patient. In an effort to serve you efficiently, we have instituted the following financial policy. The policy below outlines the understanding between you, the patient, and our office. Our office will, as a courtesy, file your insurance claims based upon the information you provided on your registration sheet; however, it is your responsibility to provide us with complete and accurate information. You will be asked to provide this information on an annual basis. Failure to provide information necessary and required by the insurance company will result in the denial of your claim. Insured parties are expected to know their plan requirements and to abide by any specifications of their insurance plan. Furthermore, if information is requested from you, by the insurance company, you must provide that information promptly. If your claim is denied, it becomes your responsibility to pay the balance in full. By signing below, you understand that you will be responsible for the payment of any services not paid by the insurance company which includes co-payments, deductibles, coinsurance, and non-covered services and denied services not covered by contract by our office and your insurer. We will assist you in any way possible to be sure the claim is handled properly; we will file your insurance claim for you, and send a reminder statement when there is a balance to be paid by you. In instances where it is deemed necessary, we reserve the right to refer uncollected balances to an outside collection agency. By keeping open lines of communication and by providing accurate information, you can be sure your claims will be handled promptly and efficiently. Thank you in advance for your cooperation.

Texarkana Eye Associates requires that all exam fees and copays be paid in full at time of service, as well as any materials ordered.

By signing below, I agree that I am ultimately responsible for payment of services provided to me. My signature below authorizes Texarkana Eye Associates to release the information necessary to facilitate the payment of medical claims.

_____ _____

Signature Date

HIPPA PRIVACY

Notice of Privacy Practices and Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose health care information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and services provided at our location, but also disclosure of your health information as may be necessary or appropriate for you to receive follow up care from another health care professional. Similarly, the use and disclosure of your health information for purposes of payment include (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third party payers and insurers and (4) other aspects of payment described in our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here in our office.

☐ I have read or had explained to me Texarkana Eye Associates' Notice of Privacy Practice and agree to continue my care with Texarkana Eye Associates' under said terms.

☐ I was given the opportunity to read Texarkana Eye Associates' Notice of Privacy Practice and declined but wish to continue my care with Texarkana Eye Associates under the terms of Texarkana Eye Associates' privacy policies.

If you would like us to release your healthcare information to anyone besides yourself, please list them below:

1. _____

   Name Relationship to Patient

2. _____

   Name Relationship to Patient

Signature_____ Date_____