Negrey Eye Associates

Patient Registration

____ M F ________/________/________ __________-__________-__________

Patient's Name **Sex** **DOB** **Social Security Number**
(required unless minor)

____

Address **City** **State** **Zip Code**

Email Address: ____

☐ ______________________________ ☐ _________________________________ ☐ _______________________________________

Home Phone **Cell Phone** **Work Phone**

Place an X in the appropriate box above to specify the preferred daytime contact number.

_________________________________ ____

Occupation **Employer Name** **Address** **Phone**

Emergency contact/relationship: ____ **Phone:** (_____)__________________

Personal Physician (PCP):
Name:_____________________________________ **Phone:** ________________________________**City/State:**______________________________

How did you hear about us?____

Guarantor: Please complete if the patient is a minor. **The person who is signing for treatment of the minor today must register as the guarantor.**

____ _______/_______/________ ________-________-_________

Name/Relationship DOB Social Security Number (required)

____

Address (if different than the patient's) City, State, Zip Code

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Is your visit today related to: ☐ **Auto Accident** ☐ **Worker's Compensation** ☐ **Other Accident** ☐ **None**

If yes, please notify the Patient Service Representative at the front desk to receive further instructions.

Primary Insurance Information

Insurance Company Name____ Policy/ID#__________________________ Group#_______________

Policyholder name/relationship____ D.O.B. _____/______/_____ SS#______-_______-______

Insured's employer name/address____ Phone:(______)_____________________

Secondary Insurance Information

Insurance Company Name____Policy/ID#___________________________ Group#______________

Policyholder name/relationship____ D.O.B. _____/______/_____ SS#______-_______-______

Insured's employer name/address____ Phone:(______)_____________________

Vision Insurance

Insurance Company Name____ Policy/ID#____

Policyholder name/relationship____ D.O.B. _____/_____/_____ SS#______-_______-_______

Medicare patients: If you have **Medicare Insurance**, are you or your spouse currently employed? Yes No
If yes, do you or your spouse have insurance through your employer? Yes No
Tricare patients: If you have **Tricare insurance,** is the policyholder active duty? Yes No

Medicare Lifetime Signature on File: I request that payment of authorized Medicare payments be made on my behalf to Negrey Eye Associates for services furnished to me. Furthermore, I have authorized to release to my insurance carrier(s) any and all information needed to determine the benefits payable to related services. Although the providers of NEA may or may not participate with my insurance carrier(s). I understand that I am financially responsible for co-payments, deductibles and unpaid balances.

____ ____

Signature of patient/guarantor Date

Negrey Eye Associates

Authorization for Contact Methods

I hereby give Negrey Eye Associates my permission to contact me at all of the contact numbers and addresses provided in order to communicate my protected health information (or that of my child) including results, prescriptions and appointment information. This communication may be via US mail, phone, answering machine, mobile phone or email. Please list restrictions below:

____

X ____ _______________________________________

Signature of Patient/Responsible Party Date

Private Insurance Authorization for Assignment of Benefits and Release of Information

I hereby authorize the direct payment of my medical benefits to Negrey Eye Associates for any services furnished to me. I authorize the doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed. If my insurance company does not pay the practice within 30 days, I will be responsible for the bill. Payment is due upon receipt of a statement from our office.

_______________________________________ _______________________________________

Patient (or Guarantor) Signature Date

To stay in compliance with the Federal Government, we must record the following information in your medical records:

Race: (circle one)	White	Black/African American		Asian	Other
Ethnicity: (circle one)	Hispanic	Not of Spanish/Hispanic Origin			
Primary Language:	English	Spanish	Indian	Russian	Other

HIPPAA Registration

Patient: _______________________________________ **DOB:** _______________________________

I acknowledge receipt of the Notice of Privacy Practices for Negrey Eye Associates.

X____ _______________________________________

Signature of Patient/Responsible Party Date

____

Printed Responsible Party Name/Relationship to Patient

Delegation of Patient Representative

By my signature below, I hereby authorize the disclosure of my Protected Health Information (PHI) (or that of my child), as well as appointments and billing information to be shared with the person(s) listed below.

____

Name Relationship Phone

____

Name Relationship Phone

X____ _______________________________________

Signature of Patient/Responsible Party Date