TEXARKANA EYE ASSOCIATES

PATIENT REGISTRATION FORM

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

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 give your insurance card to the 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 Texarkana Eye Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the clinic to release all information 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:**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Texarkana Eye Associates make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

CHECK ONE

- o 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.
- o 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.

FINANCIAL LIABILITY

Texarkana Eye Associates strives to be the leader in cutting edge technology and providing quality eye care. We try to work hard with all patients and file insurance to save patients as much out of pocket as possible, as a courtesy to patients. For our office to do this, the insurance must be presented ***PRIOR*** to the examination in order for us to call on benefits. Managed Care and HMOs have forced us to be extremely cost efficient to stay competitive and in business.

This form is simply to make sure you, the patient and/or representative, know you are financially responsible for any deductible, co-insurance, or amount that your insurance denies. Upon notification from your insurance company, which sometimes can take up to 30 days, we expect payment of any unpaid balance in one week.

All payments are due at the time the services are rendered unless ***PRIOR*** arrangements have been made with office management.

Thank you for your continued patronage and allowing us to be your eye care provider. If you have any questions concerning your insurance, please feel free to ask our Insurance Specialist.

I HAVE READ OR HAVE HAD READ TO ME AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

☐ *BY CHECKING THIS BOX YOU CERTIFY THAT THE INFORMATION IS CORRECT AND YOU ARE WHO YOU SAY YOU ARE.*

_____ _____

PATIENT SIGNATURE DATE