Friedrich Eye Associates, PLLC

# PATIENT REGISTRATION

***Please bring Photo ID, Insurance Cards, and Medication List to your appointment.***

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name** | | | | **Salutation** | |
| **Birth Date** | | **Age** | | **Birth State** | |
| **Sex** | | | | **SS #** | |
| **CURRENT ADDRESS** | | | | | |
| **Address** | | | | | |
| **ADDRESS YOUR INSURANCE COMPANY HAS ON FILE** | | | | **□ Same As Above** | |
| **Address** | | | | | |

| **COMMUNICATION** | | | | | |
|---|---|---|---|---|---|
| **Home Phone #** | | **Work Phone #** | | **Extension** | |
| **Cell Phone #** | | **Carrier** | | | |
| **Email** | | | | | |

| **INFORMATION** | | | |
|---|---|---|---|
| **Marital Status** | | **Special Needs** | |
| **Occupation** | | **Employer** | |
| **Employer Address** | | **Employer Phone #** | |

| **GOVERNMENT REQUIRED INFORMATION**<br>**Check One in EACH Section** | | | |
|---|---|---|---|
| **Primary Language** | □ English □ Spanish □ French □ Other: _____ | | |
| **Race** | □ American Indian or Alaska Native<br>□ Black or African American<br>□ Asian<br>□ Native Hawaiian or other Pacific Islander<br>□ White<br>□ Other Race<br>□ Decline to Answer | **Ethnicity** | □ Not Hispanic or Latino<br>□ Hispanic or Latino<br>□ Unknown<br>□ Decline to Answer |

| **EMERGENCY CONTACT (Please list 2 contacts)** | | |
|---|---|---|
| **Name** | **Relationship** | **Phone #** |
| | | |
| | | |

| ACCOUNT RESPONSIBLE | | | | | □ Same As Above |
|---|---|---|---|---|---|
| **Responsible** | | | **Birth date** | | |
| **Pt. Relationship** | | | **SS #** | | |
| **Address** | | | | | |
| **Home Phone #** | | **Work Phone #** | | **Extension** | |
| **Email** | | | | | |

| PRIMARY INSURANCE | | | |
|---|---|---|---|
| **Name** | | **Group Name** | |
| **ID #** | | **Group #** | |
| **Address** | | | |
| **Phone** | | | |
| **Insured** | | **Date of Birth** | |

| SECONDARY INSURANCE | | | |
|---|---|---|---|
| **Name** | | **Name** | |
| **ID #** | | **Group #** | |
| **Address** | | | |
| **Phone** | | | |
| **Insured** | | **Date of Birth** | |

| REFERRAL SOURCE | | | | | |
|---|---|---|---|---|---|
| **Referring MD** | | **Phone #** | | **Fax #** | |
| **Address** | | **City and Zip** | | | |
| **Primary MD** | | **Phone #** | | | |
| **Address** | | **City and Zip** | | | |

## FINANCIAL AGREEMENT

The financial policy has been fully explained to me and I acknowledge full responsibility for all charges incurred, including any additional charges incurred in the collection of this account, if my insurance later determines my services to be non-covered or not a benefit. I also understand that refractions are a non-covered service, but necessary for my medical care. I agree to pay the refraction fee at the time of service.

**PATIENT SIGNATURE: X**_____ **DATE:** _____

## PRIVACY POLICY

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

**Home telephone:** We may leave a message with a callback number or appointment reminder on voice mail.

**Written Communication**: We may mail postcards to your home address or send you an e-mail.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.I understand that the last four digits of my social security number will be used as a password to identify persons seeking information regarding my healthcare, test results, prescription refills, billing information. If I would like a different code assigned, I will list it here: _____. I will give this code to my family members or friends who may need to call the practice on my behalf. Without this code, the physicians or staff members will not be able to speak to anyone except myself.

**PATIENT SIGNATURE: X**_____ **DATE:** _____

## LIFETIME INSURANCE AUTHORIZATION

I authorize and request that payments under my medical insurance plan(s) be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

**PATIENT SIGNATURE: X**_____ **DATE:** _____