PATIENT REGISTRATION FORM - ADULT

Date: _____ **Patient Number:** _____

PATIENT INFORMATION

First Name | Middle | Last Name | Social Security Number

Date of Birth | Sex | Marital Status | Driver's License Number

Patient Address (Street, Route, Apt. No., Etc.) | Home Phone Number ( )

City | State | Zip Code | Email Address | Cell Phone Number ( )

Employer | Employer Phone Number | Referring Physician

INSURANCE INFORMATION

Primary Insurance Company Name | Policy Number | Group/Plan Number

Insured's Name | Insured's Date of Birth | Relationship to Patient

Secondary Insurance Company Name | Policy Number | Group/Plan Number

Insured's Name | Insured's Date of Birth | Relationship to Patient

RESPONSIBLE PARTY

Name _____

DOB _____

SSN # _____

Address _____

City, State, Zip _____

Home Phone # ( ) _____

Cell/Pager # ( ) _____

Employer Name _____

Work Phone # ( ) _____

ADDITIONAL INFORMATION

Pharmacy Name _____

Address _____

City, State _____

Phone # ( ) _____

Primary Care Physician _____

City, State _____

Phone # ( ) _____

May we communicate/correspond with your primary care physician regarding your care?

Yes ❑ No ❑ Please initial _____

Authorized Contacts (Your personal representative(s) with whom we may discuss your care).

_____

_____

Insurance:
In order to comply with your insurance **all copayments, co-insurance, deductible and/or non-covered services must be paid at the time service is rendered.** Please remember that insurance is considered only a method of reimbursement to the physician for services you have received – making you ultimately responsible. If there are any questions regarding the payment or insurance filing policies, please see one of the office staff at this time to make any necessary arrangements. Regardless of custody arrangements or divorce decrees, the person bringing a dependent in for services is responsible for all copayments, etc., and is expected to pay at the time service is rendered.

You are responsible for obtaining a referral if one is required by your insurance carrier. If we are participating providers with your carrier, we will file your claim for your office visit or surgery and allow 45 days for payment in full. Should payment not be received within 45 days, the balance due will become the obligation of the guarantor on the account and must be paid within 30 days. If you do not have insurance, or we are not a participating provider with your insurance carrier, payment is expected today for services rendered.

Agreement to Pay:
The undersigned responsible party does hereby agree to pay for all services rendered to the above-named patient. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including all costs of collection, attorney fees, and court costs, if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state. All unpaid balances will be charged a 1.5 percent rebilling fee monthly. All returned items will be assessed a $25.00 fee.

Consent to Treat:
I hereby consent to the treatment for myself or the above listed patient.

Health Insurance Portability and Accountability Act (HIPAA):
I consent to the use or disclosure of my protected health information (PHI) by Alabama Ophthalmology Associates, P.C. (the Company) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Company's Notice of Privacy Practices (the Notice) prior to signing this document. I have received a copy of the Company’s Notice. The Notice describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Company. The Notice for the Company is also provided in the main lobby of the practice and on the Company’s website at www.aoapc.com. This Notice also describes my rights and the Company's duties with respect to my PHI.

The Company reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by accessing the Company’s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature _____ Date _____