PATIENT REGISTRATION

Last Name_____ First Name_____ MI_____

Local Address_____ City_____ State_____ ZIP_____

Permanent Address_____ City_____ State_____ ZIP_____

Spouse Name_____

PLEASE PRINT Email Address_____
(Only for use by our office for communication with you. Your address will NEVER be released to an outside party)

Cell Phone _____ Home Phone_____ Work Phone_____

Age_____ Date of Birth_____ Social Security Number_____

Employer_____

Emergency Contact_____ Phone_____

Primary Care Physician_____

How Were You Referred to Our Office?_____

Insurance Information

PRIMARY INSURANCE_____

Insured ID#_____ Policy Group #_____

Policy Holder:_____ Date of Birth:_____ Relationship to Patient:_____

SECONDARY INSURANCE IF APPLICABLE_____

Insured ID#_____ Policy Group #_____

Policy Holder:_____ Date of Birth:_____ Relationship to Patient:_____

_____ I ACKNOWLEDGE I MAY REQUEST A COPY OF EYE TECH EYE ASSOCIATE'S **NOTICE OF PRIVACY PRACTICES** AT ANY TIME**.**

_____ I AUTHORIZE PAYMENT OF MEDICARE AND/OR OTHER INSURANCE BENEFITS TO BE MADE DIRECTLY TO **JOHN R. TANNER OD PLLC** FOR SERVICES PROVIDED TO ME. I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANIES AS IS NECESSARY TO PROCESS CLAIMS FOR SERVICES PROVIDED TO ME.

Print Patient Name	Signature of Patient/Legal Guardian	Date

Designation for Release of Medical Information to a Family Member, A Friend or Legal Representative

Introduction

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Privacy Statement of Eye Tech Eye Associates is the basis for how we treat your Protected Health Information. HIPAA allows physicians to use their professional judgment on disclosing certain PHI to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Our Doctors realize that there are times when you, the patient, may want another person to be knowledgeable about your medical condition, medical needs or your billing and insurance information. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, Eye Tech Eye Associates may not be able to release information to any family member or friend.

Designation Statement

☐ **I designate the following person** to speak to a physician at Eye Tech Eye Associates, a technician or other staff member, should it be necessary, on my behalf. I release Eye Tech Eye Associates, its physicians and staff, from any claim of confidentiality in connections with the release of this information. I hereby give permission to Eye Tech Eye Associates, through its physicians and staff, to release to my designee any information about:

- my medical condition **(YES NO)**:or
- my medical needs **(YES NO)**;or
- the status of my account and/or billing questions **(YES NO)**.

Designated Person Name:_____ Relationship:_____

Home Phone #_____ Work Phone #_____ Cell #_____

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Signature:_____ Date: _____ Eye Tech Eye

Associates Witness: _____ Date: _____

☐ **I decline to designate anyone to speak with my physician or clinical staff.**

Patient's Signature:_____ Date: _____

Eye Tech Eye Associates Witness: _____ Date: _____

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service. Understanding the Eye Tech Financial Policy is an essential element of our care and treatment. Please take a few moments to read following financial policy. If you have any questions, please feel free to discuss them with one of our staff members.

Unless you or your insurance carrier has made other arrangements in advance, full payment is due at the time of service. For your convenience, we accept cash, checks, American Express, Discover, Visa and MasterCard.

Your Insurance

We are contracted with many insurance plans. We will bill those plans with which we have a contractual agreement. We will collect any required co-payment at the time of your appointment or service. In the event your health plan determines a service to be *"not covered";* you will be responsible for the total charges. In that case, payment will be due upon receipt of your first statement.

If you have insurance coverage with a plan with which we do not have a contracted agreement, we will prepare and send the claim for you on an unassigned basis. If Eye Tech receives reimbursement from your insurance carrier, you will be refunded that amount. Charges for your care and treatment are due at the time of the treatment or service.

Minor Patients

The adult accompanying the minor (patient) will be financially responsible for all services rendered.

The **HIPAA HITECH Act** allows for you to pay for services out of pocket and request that we NOT bill your insurance. Please tell us if you prefer this option. You will need to sign a brief statement that specifies the date of service that you do not want to go to your insurance company. Payment in full for services rendered is required at time of service.

***I have read and understand the financial policy of the practice and I agree to its terms*.**

Signature of Patient or Responsible Party _____ Date _____

Printed Name of Patient _____

Printed name of Responsible Party (if different than the Patient) _____

Please bring these signed forms along with a list of your current medications and insurance information. Please call 623-933-6586 if you have any questions. Welcome to the Eye Tech family!