Rexburg Vision Center
Patient Registration

Revised May 2010

PERSONAL INFORMATION

Last Name_____

First Name_____ **MI**_____

Mailing Address:

_____

_____ _____ _____
City State ZIP

Phone Numbers:

Home:_____ Work:_____

Mobile:_____ Other:_____

Gender: Male / Female Date of Birth_____

Age_____ Social Security #_____

Single__ Married__ Widowed__ Divorced__ Separated__

If married or a single minor, please complete the Spouse / Parental information on the right.

Are you a University Student? Yes / No

All single college students MUST complete the Parental Information to the right.

University_____

Employment:

Employer_____

Occupation_____

RESPONSIBLE PARTY

Who is responsible for this account? (Circle One)

Self Parent Spouse Legal Guardian

Other_____

INSURANCE INFORMATION

If you have MEDICAL or VISION insurance coverage, this section must be completed.

Primary Insurance Carrier_____

Policy or ID Number_____

Policy Holder's Name_____

Policy Holder's SSN#_____

Policy Holder's Date of Birth_____

Relationship to Patient: Self Parent Spouse Legal Guardian

Secondary Insurance Carrier_____

Policy or ID Number_____

Policy Holder's Name_____

Policy Holder's SSN#_____

Policy Holder's Date of Birth_____

Relationship to Patient: Self Parent Spouse Legal Guardian

SPOUSE / PARENTAL INFORMATION

All single college students and minors MUST complete this section.

Name:_____ Relation:_____

Date of Birth_____ Age_____

Mailing Address: ___ Check here if address is the same.

_____

_____ _____ _____
City State ZIP

Phone Numbers:

Home:_____ Work:_____

Mobile:_____ Other:_____

MEDICAL INFORMATION

Do you have problems with any of the following systems:

__Gastrointestinal __Endocrine __Immunologic
__Ears/Nose/Throat __Nervous __Genitourinary
__Cardiovascular __Masculoskeletal __Integumentary (Skin)
__Respiratory __Mental __Blood / Lymph

Are you Diabetic? Yes / No Type___ How long?_____

Are you Insulin Resistant? Yes / No How long?_____

Please explain any health conditions_____

_____

_____

_____

List of Current Medications: _____

_____ _____

_____ _____

_____ _____

Please list any allergies you may have -including medications.

_____

Name of Physician_____

Date of Last Visit_____

Do you or your relatives have: High Blood Pressure__ Diabetes__
Glaucoma__ Macular Degeneration__ Retinal Detachment__
Have you had an eye operation? Yes / No Date_____
Have you had an eye injury? Yes / No Date_____
Do you have: Glaucoma__ Dry Eyes__ Cataracts__

Please list any other eye conditions. _____

_____

Name of Previous Eye Doctor_____

Date of Last Visit_____

HOW DID YOU FIND OUT ABOUT US?

Advertisement: Marquee___ Yellow Pages___ Ad___
Referral: Family___ Friend___ Professional___
Whom may we thank for referring you?_____

Other_____

ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of any authorized insurance benefits as determined by my insurance carrier (including Medicare and Medicaid) for products or services, otherwise payable to me, be made on my behalf to the Rexburg Vision Center. I authorize the Rexburg Vision Center to release any personal or medical information necessary to my insurance carrier to secure these benefits. The Rexburg Vision Center accepts the charge determined by your insurance carrier as the full coverage amount and that you or your responsible party is accountable for any deductibles, co-payments, co-insurance, overages, and non-covered services. I understand that if the Rexburg Vision Center is not a contracted provider of my insurance, I am responsible for the full amount owing on my account and must submit the claim personally for reimbursement.

Medicare:

If another insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing my information to the insurer or agency shown to secure any potential benefits.

NON-COVERED SERVICES

I understand that Rexburg Vision Center's contracts with health care service plans (i.e HMO's, PPO's) relate only to products and services which are covered by the health care service plan. Accordingly, I accept full responsibility for all products and services which are determined by my health care plan not to be covered. Examples of non-covered services include 1) products or services not specified as being covered in the patient's insurance contract, 2) treatment or tests not authorized by the insurance carrier or health care plan.

RELEASE OF INFORMATION

The Rexburg Vision Center may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illnesses, communicable diseases, or HIV to any person, agency, or health care provider 1) which is or may become liable or under contract to the Rexburg Vision Center for reimbursement for products or services provided, 2) who will be assuming care of the patient. I understand that the Rexburg Vision Center may be required to disclose any information concerning my case pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

FINANCIAL AGREEMENT

I understand that payment for the products and services provided to me by the Rexburg Vision Center must be made in full at the time of service. If a full payment cannot be made at the time of service, I agree to the conditions set by the Office Manager or Doctor for regular payments on my account until the amount has been satisfactorily paid in a timely manner. I understand that if my account is delinquent, late fees and penalties may apply and my account is also subject to a legal interest rate. I am aware that if I do not pay the full amount owing in a timely manner according to the conditions outlined for me, that my account may be sent to an attorney or collection agency and I will be responsible for collection expenses and/or attorney fees. I am aware that if my account is placed in collections, it may also be negatively reported to a credit bureau by the collection agency or attorney.

HIPAA ACKNOWLEDGMENT

I acknowledge that I am aware of my patient rights as determined by HIPAA and have been offered a copy of the Rexburg Vision Center's Notice of Privacy Practices. I understand that my personal and medical information will not be released to any person, entity, or agency without my written permission.

I, the undersigned, am aware of the terms and conditions set forth by the Rexburg Vision Center for products and services provided to me (or to my dependent). I understand my rights, privileges, and responsibilities as a patron of this establishment. I also understand my obligation to fully comply with the policies outlined in this document.
(Only sign once.)

_____ _____

Patient Signature (or Authorized Party) Date

_____ _____

Patient Signature (or Authorized Party) Date

_____ _____

Patient Signature (or Authorized Party) Date

_____ _____

Patient Signature (or Authorized Party) Date