

Patient Registration

Dr. Miss

Mr. Ms.

Mrs.

Circle One First Name Middle Last name Date of Birth Social Security #

Address City State Zip

Home Phone Cell Phone Work Phone Email

Employer Name/Address Spouse

Race

- ☐ American Indian or Alaskan American
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ Caucasian/White
☐ No Answer Given

Ethnicity

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ No Answer Given

Preferred

Contact Method

- ☐ Home Phone
☐ Cell Phone
☐ Email
☐ Text

How did you hear about us?

- ☐ Already a Patient
☐ Phone Book
☐ Dr. Referral
☐ Insurance Listing
☐ Website
☐ Facebook
☐ Friend _____
☐ Family _____

Gender

- ☐ Male
☐ Female

Preferred Language

- ☐ English
☐ Other (please specify) _____

Insurance Information

Vision Insurance Name Policy Number Group Number

Insured's Name Insured's Date of Birth Insured's Social Security # Relationship to Patient

Responsible Party (if different than patient)

Name _____

Date of Birth _____

Soc Sec # _____

Address _____

City/State/Zip _____

Home Phone _____

Cell _____

Employer Name _____

Work Phone _____

Additional Information

Primary Physician _____

City _____

May we communicate/correspond with your primary physician regarding your care? Circle one Yes No Please initial _____

Pharmacy/City _____

May we share relevant medical conditions to your vision insurance for billing purposes? Circle one Yes No Please initial _____

I authorize doctors and staff to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following individuals:

Name/Relationship _____

Name/Relationship _____

See Reverse

Please read carefully.
If you are completing this form for a dependent, the following statements will apply to them.

Consent to E-Prescribing
E-Prescribing is defined as a physician's ability to electronically send error free, accurate, and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Niles Vision Clinic, P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Niles Vision Clinic, P.C. to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ Patient Name- Print	_____ Patient Date of Birth	_____ Signature of Patient or Legal Representative
_____ Relationship to Patient	_____ Date Signed	_____ Print Patient Representative Name

INSURANCE
Niles Vision Clinic is committed to caring for our patient's complete ocular health. Our patient's will receive a **Complete Eye Health Examination**. Our doctors are trained to diagnose and treat ocular diseases. As a courtesy, we are happy to file with your insurance company. Please note that **all co-payments, co-insurance, deductible and/or non-covered services must be paid at the time that services are 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 co-payments, etc., and is expected to pay at the time the 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 visit. Any portion not covered by insurance is the obligation of the guarantor on the account.

Routine vision exams will be filed with a patient's vision plan if one is available and we are a participating provider. A routine exam means that there is not a medical diagnosis. Routine diagnoses include myopia (near farsightedness), hyperopia (farsightedness), astigmatism and presbyopia. If a medical diagnosis (cataracts, glaucoma suspect, foreign body, diabetes, dry eye, etc.) is determined by the doctor, the patient's exam is no longer routine, but medical. This means we would bill your medical health plan. We request a copy of your medical insurance card(s) annually for this purpose. In this instance, your insurance copay and deductible would apply.

Niles Vision Clinic takes pride in providing the best care and products for our patients. We will strive to resolve all of your eyecare and optical needs.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I consent to the use or disclosure of my protected health information (PHI) by Niles Vision Clinic, P.C. for the purpose of diagnosing or providing treatment to me, and/or obtaining payment for my health care or routine vision bills.

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

I acknowledge that I have been made aware of the public location of the Notice of Privacy Practices (Revised 09/23/2013) within the reception area of Niles Vision Clinic and/or have received a copy of the Notice of Privacy Practices. 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 Niles Vision Clinic.

_____ Signature of Patient or Responsible Party	_____ Date
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