MEP PATIENT REGISTRATION

NAME: _____ SEX(Circle One): MALE FEMALE

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY#: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOES YOUR CELL PHONE HAVE A CAMERA? (Circle One): YES NO

MARITAL STATUS(Circle One): MARRIED WIDOWED DIVORCED SINGLE

IS PATIENT A RESIDENT OF A SKILLED NURSING FACILITY? (Circle One): YES NO

EMERGENCY CONTACT INFORMATION:

NAME: _____

RELATION: _____

PHONE: _____

PHYSICIAN INFORMATION:

REFERRING EYE DOCTOR: _____ PHONE: _____

FAMILY DOCTOR: _____ PH: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION – ONLY MEDICAL HEALTH PLANS WILL BE BILLED – NO VISION PLANS

PRIMARY HEALTH INSURANCE:

INSURANCE COMPANY: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SECONDARY HEALTH INSURANCE:

INSURANCE COMPANY: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ ACCEPTANCE OF HIPPAA REGULATIONS

I hereby authorize Midwest Eye Professionals (MEP), and its agents, to release to and discuss with my insurance company, physician, and/or employer, for work related injuries, any information acquired by MEP in the course of my examination or treatment. I hereby authorize benefits to be paid directly to the provider. I understand that payment of charges is not contingent upon settlement from my insurance carrier and that I am responsible for any unpaid balance. Please note that any and all patient accounts that require any outside collection assistance will be charged an additional fee of $25.00 as well as any attorney or court costs. If an appointment is missed or canceled without 24 hour notice, there will be a $30 fee charged to your account. Our notice of privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing consent. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reference to your prior consent.

PATIENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____