ARBOR
CENTERS FOR EYECARE

PATIENT REGISTRATION FORM

DEMOGRAPHIC INFORMATION					
Name		**Preferred Name**			
Address 1		**Address 2**			
City		**State**		**Zip Code**	
SS#		**Date of Birth**			
Sex		**Marital Status**	❑ Single ❑ Married ❑ Other		
Home Phone		**Mobile Phone**			
E-Mail		**Preferred Contact Method**	❑ Home ❑ Cell ❑ Work		
Are there any restrictions to contacting you?					
Race	❑ Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other	**Ethnicity**	❑ Non- Hispanic ❑ Hispanic (please specify):		
Language	❑ English ❑ Spanish ❑ Other (please specify):				

EMERGENCY CONTACT INFORMATION			
Name		**Relationship**	
Home Phone		**Work Phone**	

WITH WHOM MAY WE SPEAK ABOUT YOUR CARE?			
Name		**Telephone**	
Relationship			

EMPLOYMENT INFORMATION					
Employer		**Occupation**			
Address 1		**Address 2**			
City		**State**		**Zip Code**	

DOCTOR INFORMATION	
Referring Doctor	
Primary Care Physician	

HOW DID YOU HEAR ABOUT OUR OFFICE?	
Referral Source	

PHARMACY INFORMATION			
Pharmacy Name		**Pharmacy Phone**	
Pharmacy Location (City, State, Intersection, etc.)			

INSURANCE INFORMATION					
Ins. Policy Holder		**Relationship**			
Date of Birth		**SS #**			
Address 1		**Address 2**			
City		**State**		**Zip Code**	

I have read and understand the following forms that were provided to me today:

❑ Do you need a referral? ❑ Notice of Privacy & HIPAA ❑ Responsibility of Payment ❑ Refraction Policy

Signature: ______________________________ Date: ______________

DO YOU NEED A REFERRAL?

In accordance with many health insurance plans, patients must often obtain a referral form or authorization number from their insurance plan or primary care doctor before they can be examined by physician specialists. ***It is your responsibility to determine whether or not your insurance plan requires prior authorization or a referral to be seen by one of our doctors prior to your visit.***

If your health plan requires special authorization to see a specialist, it is your responsibility to obtain the necessary paperwork prior to your visit. As much as we would like to help, we cannot obtain authorization for you. In fact, many health plans will not allow us to call for same-day authorization. If you do not have a referral, a non-emergency appointment may have to be rescheduled. Alternatively, you may pay us directly at the time of service if you wish.

Those of our patients who need to obtain prior authorization for service must remember that, unless instructed otherwise by one of our staff, ***you will need a referral form or authorization number for each and every visit to our office.*** In addition, separate referral authorizations are often required for visual field tests, nerve fiber tests, fundus photography and surgical procedures.

I have read the above and understand that if my health insurance requires me to obtain prior authorization to see a specialist or have any tests performed, and I chose to proceed with the examination or tests without prior authorization, that I am responsible for payment at the time of the visit.

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I hereby give my consent to Arbor Centers for EyeCare to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record.

I acknowledge receipt of the doctor's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the doctor has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me at the time of my next visit after such revision and will be posted in the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the doctor. I also understand that I will not be able to revoke this consent in cases where the doctor has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the doctor's office.

RESPONSIBILITY FOR PAYMENT

I understand that my health insurance carrier, employer, or workman's compensation may not cover the cost of services rendered. I understand that the fee for these services may be counted against any deductible or out-of-pocket expenses mandated by my insurance plan. If my health insurance carrier, employer, or workman's compensation denies payment for any reason, including failure to obtain the proper referral, I agree to be personally and fully responsible for payment of services rendered.

I also agree that I am responsible for immediately notifying Arbor Centers for EyeCare of any changes in my insurance prior to surgery or service. If I fail to notify Arbor, and the changes in my insurance result in non-payment of services, I will be responsible for all fees due for any services rendered.