THE BRIMHALL EYE CENTER

Patient Registration Form

Please fill out the following form completely. All information will be kept safeguarded & confidential.

Patient Information				
Last Name	First Name		Preferred Name	Sex: ☐M ☐F
Date of Birth	Patient SSN		How did you hear about us?	
Home Phone	Cell Phone		Optometrist	
Address/City/Zip			Primary Care Physician	
Email	Pharmacy Name		Pharmacy Phone	
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed		Employer		Occupation
Spouse Name	Spouse DOB	Spouse SSN		Spouse Employer

Responsible Party Information (For example: Parent/Legal Guardian Information, if Patient is a minor)		
Last Name	First Name	Sex: ☐Male ☐Female
Address		
Home Phone	Cell Phone	Email
SSN	DOB	Relation

Primary Insurance Information			
Insurance Company Name			Effective Date
ID Number		Group Number	Plan Type: ☐HMO ☐PPO ☐Other
Name of Subscriber/Policyholder			Relation: ☐Self ☐Spouse ☐Parent ☐Other
SSN	DOB	Sex: ☐Male ☐Female	Employer
Insurance Company Address		City	State/ZIP
Insurance Company Phone			
Secondary Insurance Information (If applicable)			
Insurance Company Name			Effective Date
ID Number		Group Number	Plan Type: ☐HMO ☐PPO ☐Other
Name of Subscriber/Policyholder			Name of Subscriber/Policyholder
SSN	DOB	Sex: ☐Male ☐Female	Employer
Insurance Company Address		City	State/ZIP
Insurance Company Phone			

Emergency Contact Information	
Name	Relation
Primary Phone	Alternative Phone

Patient/Guardian/Responsible Party Initial: _____

Patient Information		
Last Name	First Name	Date of Birth

Background Information			
Due to recent legislation changes, the government is requiring medical facilities to collect the following information. **Please Circle all that applies**			
Ethnicity/Race		**Primary Language Spoken**	
American Indian	Alaska Native	Chinese	Spanish
Black or African American	Native Hawaiian	English	Russian
Hispanic/Latino	Pacific Islander	German	French
White/Caucasian	Other:	Japanese	Other:

FINANCIAL AGREEMENT

The following is our Financial Policy, which will help you understand our billing and payment procedures.

- **ALL INSURANCE CARDS and a PHOTO ID WILL BE REQUIRED FOR COPYING OR SCANNING**.
- Patients are responsible for Deductible Balances, Co-Insurance and Non-Covered Amounts.
- Payment(s)/Co-Payment(s) are due at the time service is rendered. **Initial: _____**
  - We accept Cash, Checks, Money Orders, Debit Cards, and All Major Credit Cards. There will be a $25.00 fee for all returned checks.
- No Show Policy: There is a $30.00 No Show Fee **Initial: _____**
  - At least 24 hour notice is required to cancel or rescheduled your appointment.
  - For same day appointments a 2 hour notice is required.
- Medical forms to be filled out by Dr. Brimhall are $10.00/page. FMLA packets are $40.00 **Initial: _____**
- The Brimhall Eye Center does not dispense or provide prescriptions for glasses or contacts. Any refraction testing is done for diagnostic purposes. We will we refer you to an Optometrist for a glasses or contact prescription. **Initial: _____**
- Any changes or updates of insurance, address, phone number or emergency contact information should be reported immediately.
- We will submit an insurance claim on your behalf and whatever the insurance(s) does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement.

- You are responsible for knowing your insurance benefits.
- Remember that insurance authorizations/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. Should your account become delinquent, it will be referred to a collection agency. You shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle the greater of $25 or an amount 35% in excess of the balance owed.
- I request that payment of authorized Medicare/or any third party benefits be made to THE BRIMHALL EYE CENTER on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents or any third party payer any information to determine these benefits or the benefits payable for related service.
- If your account is over paid and a credit is smaller than $5.00, a refund check will not be issued, due to handling expense. The credit will remain in my account for future visits.

I certify that the above information is true and correct. I hereby authorize my insurance benefits to be paid directly to the facility and physician and I am financially responsible for non-covered services, deductibles, and coinsurance. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge and agree that I have access and can receive a copy of the BEC Privacy Policies.

_____ _____

Patient/Guardian/Responsible Party **Date**

Acknowledge Receipt of
Notice of Privacy Policies

Release of PHI to Specified Parties

Do we have permission to release your protected health information to anyone involved in your care? YES NO

If "YES", list the **name(s)** of the person(s) who has permission for access to your protected health information. Please do not use general descriptions such as **"family", or "friend".** We need name, relationship and telephone number. Also, list information they have access to, for example, "entire medical records", "specific dates", "specific types of examination", etc.

Name	
Telephone	
Relationship	
Information	

Name	
Telephone	
Relationship	
Information	

Name	
Telephone	
Relationship	
Information	

Name	
Telephone	
Relationship	
Information	

My signature below acknowledges the receipt of The Brimhall Eye Center's Notice of Privacy Policies.

I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely unless revoked in writing.

Patient Name: _____

_____ _____

Patient/ Legal Guardian/Responsible Party Signature **Date**

Relationship to patient _____

(i.e. patient is a minor)

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY

Patient named below refused to sign an acknowledgement for the receipt of The Brimhall Eye Center's Notice of Privacy Policies.

Date: _____ Office Staff Signature: _____

THE BRIMHALL EYE CENTER

Patient Name: _____ Date of Birth: _____

Smoking Status:

- Are you a tobacco user? Yes / No
- *If yes*:
  - Are you a current tobacco smoker? Yes / No
  - Are you a current smokeless tobacco user? Yes / No

Please list all of your medications that you currently take:

Please list all of your allergies:

_____ _____

Patient Signature Date