BINGHAMTON EYE ASSOCIATES

PATIENT REGISTRATION FORM

Date__________ **Referred by** ________________ **Family Doctor** ______________________

PATIENT INFORMATION

Name (Mr. Mrs. Ms.)____

Mailing Address ____
P.O. Box Street City State Zip

Date of Birth ___________ **Age** ___________ **M/F** ______ **Soc. Sec. #** ______________________

Phone: Home #_____________ **Cell #**_____________ **Email**________________________________

Employer______________________________ **Employer phone #**____________________________

Spouse Name____ **DOB**______________

Please let us know how we can contact you with appointment/medical information, check all that apply:

- ❑ Home Phone
- ❑ Work Phone
- ❑ Send via Mail
- ❑ Mobile Phone
- ❑ With Another Person
- ❑ Send via Email/Portal

IN CASE OF EMERGENCY NOTIFY:

Name:________________________________ **Relationship**________ **Phone**____________________

PARENT/GUARDIAN/RESPONSIBLE PARTY

Name__________________________________ **Soc. Sec. #** ____________________________

Address________________________________ **Phone#** _______________________________

Employer _______________________________ **Employer Phone#**________________________

INSURANCE INFORMATION

Primary Ins. Company_____________________ **Policy #** ____________________________

Secondary Ins. Company __________________ **Policy#**_____________________________

INSURANCE/MEDICARE/ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Binghamton Eye Associates for any services furnished to me by Binghamton Eye Associates. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration)/Insurance Company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim, whether on the HCFA 1500 form or other approved format of claims submission.

Over ➤

____ ____________
Insurance/Medicare/ Beneficiary or authorized Signature Date

With my consent **Binghamton Eye Associates** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Binghamton Eye Associates' **Notice of Privacy Practices** (updated 9/2013) for a more complete description of such uses and disclosures.

With my consent **Binghamton Eye Associates** may contact me by mail, phone (answering machine/ voicemail) and fax at my home or other designated location, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements, messages pertaining to my clinical care. Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. I have the right to request that Binghamton Eye Associates restrict how it uses or discloses my PHI. However the practice is not required to agree to my request, but if it does, it is bound by this agreement.

By signing this form I am consenting to **Binghamton Eye Associates'** use and disclosure of my PHI to carry out treatment, payment and operations and **acknowledging receipt** of the **Notice of Privacy Practices.** I may revoke my consent in writing except to the extent that the practice had already made disclosures in reliance upon by prior consent. If I do not consent to the use of information for treatment, payment and operations, **Binghamton Eye Associates** may decline to provide treatment to me.

Signed (patient/parent, if minor/guardian)

____ Date __________________

GUARANTEE OF PAYMENT

I agree that in return for the services provided by Binghamton Eye Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Binghamton Eye Associates for payment. I understand that if I am covered by Insurance, I am responsible for payment of all co-pays, coinsurance, deductibles and non-covered services. I understand that any unpaid balances on my account maybe turned over to an outside collection agency and I am responsible for the balance and any fees incurred by that agency.

Signed (patient/parent, if minor/guardian) ____