WILSON EYE ASSOCIATES, OPTOMETRISTS, PA
PATIENT REGISTRATION FORM
Please Print and complete all Blanks

*****Please Give ALL Vision and Medical Insurance cards to the Front Desk*****

Chart: _____ (office use) Appointment Date: _____

Patient's Full Name: _____

Sex: (please circle) M F Date of Birth: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____, OK to Text? _____ Email: _____

Marital Status: (please circle) Single Married Divorced Widowed DP

Are you: (please circle) Employed Retired Student Other

Employer Name: _____

Employer Address City: _____State: _____

Family Physician Name: _____

List the name(s) of all vision and medical insurance:_____, _____

_____, _____

Insured's Name:_____

DOB:_____

Employer Name:_____, SS#_____- _____- _____

HIPAA Consent to release Medical, Financial and/or Personal Information to Others

Important, Please Read:

Please list below the name and relationship of any family members, friends or contacts that we may disclose any of the above titled information, about you. If this form is for your child, please list their school's name or nurse to release information to them about your child's vision.

Name: _____ Relationship _____

Name: _____ Relationship _____

Emergency Contact Name and Phone Numbers

Name: _____ Phone # _____

Name: _____ Phone # _____

If Patient is in School Please Fill Out The Following:

School Name: _____ Contact/School Nurse _____

Children under the age of 18, List parent/guardian here: Mother _____ Father _____

Guardian _____, Other _____

Please complete back page →

HIPAA PATIENT CONSENT

Use and Disclosure of Protected Health Information and Acknowledgment of our Notice of Privacy Practice

I hereby give my consent for Wilson Eye Associates, to use and disclose protected health information about me to carry out treatment, payment and health care operations. The Notice of Privacy Practice provided by Wilson Eye Associates, describes such uses and disclosures. The Notice also describes my rights concerning the use and disclosure of my protected health information. I understand that I can file a complaint, if I believe that my information is not being protected or that my rights have been denied.

I have the right to revoke my consent at any time. I understand that should I revoke this consent and limit or restrict the use of disclosure of my information I must describe the restrictions and limitations in writing. I must submit such written restrictions and limitations to the contact person listed in the Notice. I understand that should I revoke my consent that the information already used or disclosed based on my consent cannot be reserved.

Wilson Eye Associates has the right to change their Privacy Practice Notice at any time. If Wilson Eye Associates changes their Notice, the new Privacy Practice Notice will apply to all health information that they already have as well as to such information that they may generate in the future.

I have been given the opportunity and encouraged to read the Privacy Practice Notice in the full detail. By signing this Consent, I have agreed to the use and disclosure of my information as described in the Notice without restriction or limitations. This consent also serves as my acknowledgment of reading the Notice and the opportunity to obtain my own copy in full detail. **(Please ask the Front desk to provide you a complete copy of our Privacy Practice Notice if you desire to have a copy for yourself.)**

Patient's Name (please print): _____Today's Date: _____

Signature of Patient or Authorized Agent: _____

Relationship, if other than patient: _____

INSURANCE DISCLAIMER:

I hereby authorize all of my insurance benefits to be paid directly to Wilson Eye Associates, Optometrists, PA. I realize that I am responsible for all non-covered services and medical expenses incurred with this office, including an eye refraction. It is my responsibility to ensure that I have given Wilson Eye Associates a current copy of my insurance card and/or the name of my vision insurance. It is my responsibility to inform Wilson Eye Associates should I have a change in insurance, prior to each visit. If I do not provide Wilson Eye Associates with the correct insurance information at the time of each visit, it will be my responsibility to pay for all services received at the time of the service and to file my own insurance claims. **If for any reason your account requires legal action or referral to our collection agency, you may be charged additional fees.**

By signing this form, I state that I have read and agree to the provision stated above.

_____ _____ _____

Signature of Patient or Responsible Party Today's Date

_____

Print name of Parent or Responsible Party

_____

Witness of Wilson Eye Associates, Optometrists, PA

******All Co-payments and non-covered services are due at the time of service.***
Please present all insurance cards (Both Medical and Vision) to the Front Desk.***
