WEA-PATIENT REGISTRATION FORM

Please Print and complete all Blanks

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 ____ Email Address_____

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

Preferred Language:_____Race:_____Ethnicity:_____

Are you: (please circle) Employed Retired Student Other

Employer Name: _____ City: _____ State_____

Family Physician Name: _____

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

Policy Holder: _____Policy Holder's Date of Birth:_____

Policy Holder's Employer: _____, Policy Holder's SS# _____-_____-_____

Emergency Contact Name and Phone Number

Name:_____ **Phone:**_____

HIPAA PATIENT CONSENT (PLEASE SIGN BELOW)

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

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.)**

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.

_____ _____

Signature of Patient/Guardian/POA **Date**

Important, Please Read: Release of Medical, Financial and/or Personal Information to Others

Please list below the name and relationship of any family members, friend or contacts that we may disclose any of the above titled information, about you.

Name: _____ Relationship _____

Name: _____ Relationship _____

Please complete back page ⟶

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.

_____ _____

X Signature of Patient or Responsible Party Today's Date

_____

Print name of Patient or Responsible Party

_____

Witness of Wilson Eye Associates, Optometrists, PA

Patient Consent/Authorization Request to Receive Personal Email (Please read before signing)

The following documents can be emailed to you with this signed consent:
Eyeglass and/or contact lens prescription, billing statement, work or school excuse.
Records/office notes can not be emailed

Email risks include but are not limited to the following:

- Email can be immediately broadcasted worldwide and received by many intended and unintended recipients;
- Recipients can forward email messages to other recipients without the original sender's permission or knowledge:
- Users can easily send an e-mail to the incorrect address;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy;
- Without the benefit of face-to-face interaction, emails can be misinterpreted in tone and meaning;
- Records or office notes can not be emailed.
- If you consent to the use of email, you are responsible for informing Wilson Eye Associates, staff of any type of information that you do not want sent to you by email other than the information listed and checked above.
- You are responsible for protecting your password and access to your email account and any email you send or receive from Wilson Eye Associates to ensure your confidentiality. Wilson Eye Associates, doctors and staff cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.
- Any email that you send that discussed your diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must submit a written consent either by U.S Postal service or email informing Wilson Eye Associates that you are withdrawing consent to email information.

I am requesting that Wilson Eye Associates, email information to me at the following email address when requested by me.

Email: _____
Please print email neatly and legible

Patient Name: _____ **Patient DOB:** _____ **Last 4 digits of SS#:** _____
Please Print

X Signature of Patient/Parent/Guardian/POA: _____

Relationship to Patient: _____

If parent/Guardian/POA, Cell Phone: _____ Home phone: _____ Date: _____

_____ Yes, I have read all information above and consent to encrypted/confidential email of the information I have checked and/or requested.

******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.***