Keszei Vision Care, PLC PATIENT REGISTRATION

Patient Name: _____ **Today's Date:** _____
Last **First** **Middle**

Date of Birth_____ **Gender:** **M** ◯ **F** ◯

Marital Status **Single** ◯ **Married** ◯ **Divorced** ◯ **Widowed** ◯

Phone #: Home: _____ **Mobile:** _____

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below. * By answering yes to email, you are accepting the risk involved by sending and receiving non-secure email.

Preferred Phone Number: Home ◯ Mobile ◯ OK to leave Voicemail? Yes ◯ No ◯

Preferred Contact Method: Phone ◯ Portal ◯ Email ◯ Email? Yes ◯ No ◯ Text? Yes ◯ No ◯

E-mail address:_____

Home Address_____

City_____State_____ Zip Code_____

PHARMACY INFORMATION:

_____ _____ _____ ____ _____ _____
Preferred Pharmacy | Street Address | City | State | Zip | Phone #

Referred by:_____ **Primary Care Provider:**_____

* By answering yes to email, you are accepting the risk involved by sending and receiving non-secure email.

Primary Insurance Company	**Plan Name**	**Policy Type**
Policy ID#	Group #	Effective Date
Subscriber Name		**Policy Holder**
Social Security Number	Date of Birth	Employer

Spouse's name (Parent name if minor)_____ Spouse's Phone Number:_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____Relationship_____

How did you hear about our practice? _____

Signature Page Keszei Vision Care, PLC

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to **Keszei Vision Care, PLC** to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and noncovered charges that apply.

X_____ _____

Patient's initials **Today's date**

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Keszei Vision Care, PLC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, and friend)

Name of Person or Entity:_____Relationship:_____

Telephone # _____

Is this person your Power of Attorney for medical purposes? Yes ◯ No ◯

I HEREBY AUTHORIZE Keszei Vision Care, PLC to examine and treat me, or the individual for whom I am responsible. ***During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare. Driving an automobile, or operating machinery, is not advised until the effects of the drops have worn off.

X_____ Initials of the Patient or Patient Representative

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

X_____ Initials of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

X_____ Initials of the Patient or Patient Representative

I voluntarily consent to provide Keszei vision care access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my doctors and staff here, and it may include prescriptions dating back for several years.
I acknowledge that Keszei Vision Care may use health information exchange systems to electronically transmit, receive and/or access my prescription history.
I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Keszei Vision Care, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

X_____ Initials of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to **Keszei Vision Care, PLC**

X_____Signature of the Patient or Patient Representative