PATIENT REGISTRATION SHEET-CHILD/STUDENT **Today's Date** ________________

How did you hear about us? ___**Website** ___**Facebook** ___**Newspaper** ___ **Friend**
___ **Family Member** ___**Doctor Referral** **Other** ____

Name____
FIRST NAME MIDDLE INITIAL LAST NAME
Mailing Address: ____
City and State: ____Zip Plus 4: __ __ __ __ __ - __ __ __ __

Parent's e-mail address: (required, if available)____

Sex: M F
Social Security Number: __ __ __ - __ __ - __ __ __ __ **Date of Birth:** __ __- __ __ - __ __ __ __
Race: (circle one) White American Indian or Alaskan Asian Black/African American Other ______________
Ethnicity: (circle one) NOT Hispanic or Latino Hispanic or Latino Unknown
Primary Language: (circle one) English Spanish Other__________________________________
Home Phone Number: ( )________________ **Child's Cell Phone Number:** ( ) ____________
Carrier: (Circle one) Verizon AT&T Sprint Alltell Tracfone Other____________
Reminder call preference: (circle one) call home phone / call cell phone/ email / text message

Who is responsible for payment ? ________________________ Relationship: ________________________
Address: ____ Phone #: _______________________
City, State, Zip: ____

Mother's Name____
Mother's Employer ___________________________________Work Phone # ________________________
Mother's Cell Phone#: ________________Carrier: (Circle one) Verizon AT&T Sprint Alltell Tracfone ________
Father's Name____
Father's Employer ____________________________________Work Phone # ________________________
Father's Cell Phone #:_________________Carrier: (Circle one) Verizon AT&T Sprint Alltell Tracfone ________

Brothers and Sisters ____

Alternate contact person not living in the home (example: grandparent, relative)
Name: _____________________________________ Relationship:_______________________________
____ Phone: ____ ____________________

Insurance Information: (Please present insurance cards to the receptionist to be copied)
Health Insurance Name: _________________________________Policy Number: _____________________
Policyholder Name: _______________________ Policyholder Date of Birth: __ __/__ __/__ __ __ __

Vision Insurance Name: ______________________________ ___Policy Number: _____________________
Policyholder Name: _______________________ Policyholder Date of Birth: __ __/__ __/__ __ __ __

Medicaid: __ __ __ __ __ __ __ __ __ Primary Care Provider: __________________________

IMPORTANT!!
PLEASE COMPLETE OTHER SIDE

12/18/18 updated

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The HIPAA Privacy Rule gives individuals a fundamental right to be informed of the privacy practices of health plans and health care providers, as well as to be informed of their privacy rights with respect to their personal health information. This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

This represents a summary of your rights. The complete notice is available by requesting it from our receptionist, or going to our website at www.mabeeeyeclinic.com

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

It is the patient/guardian responsibility to know their insurance coverage. Patients should be aware of their benefits, including which providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co pays, and when they are eligible for services. If you are not familiar with your plan coverage, we recommend you contact your carrier directly prior to your services.

The patient/guardian authorizes payment of all private insurance, medical/surgical benefits, including major medical benefits to go to the Mabee Eye Clinic. A photocopy of this assignment is to be considered as valid as an original. The patient/guardian is financially responsible for all charges regardless of insurance.

Parent/Legal Guardian Signature ____ Date ______________________

Parent or Legal Guardian must sign if patient is under 18 years old

The Mabee Eye Clinic may share medical and/or billing information with the following persons involved with my care:

______________________________ ______________________________ ______________________
Name Relationship Date

______________________________ ______________________________ ______________________
Name Relationship Date

______________________________ ______________________________ ______________________
Name Relationship Date

Patient/Guardian Signature ____ Date ______________________