

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**

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 _____