CLAY EYE CENTER PATIENT REGISTRATION

Welcome to our practice. We respect that all your information is private and confidential

Patient Information

Name _____ Date of Birth _____

Address_____ Gender □ M □ F

City _____ State _____ Zip _____

Home Phone_____ Work Phone _____ Cell Phone _____

Email Address _____

Can we send you appointment reminders by email or cell phone? ❑ Yes ❑ No

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

Name and location of Pharmacy you commonly use _____

Who is your primary physician? _____

Person to contact in case of emergency_____ Phone _____

Parental Information for Minors

Father's Name_____ Mother's Name_____

Address_____ Address_____

_____ _____

Phone H_____ W_____ Phone H_____ W_____

Main Parent's Email: _____

Insurance Information

Name of insured _____ Relation to patient_____

Birthday_____ Date employed _____

Name of employer _____Work Phone _____

Work Address _____ City _____State _____ Zip _____

Insurance Company_____ Group # _____

If you have additional insurance, please complete the following:

Name of insured _____ Relation to patient_____

Birthday_____ Date employed _____

Name of employer _____Work Phone _____

Work Address _____City _____State _____ Zip _____

Insurance Company_____ Group # _____

Thank you so much for your cooperation.

Patient Medical and Surgical Profile

NAME _____ DOB_____

SOCIAL HX: Occupation_____

FAMILY MEDICAL HX:

Diabetes_____ Strabismus_____
Cataracts_____ Amblyopia_____
Glaucoma_____Retinal Ds_____
Other_____

SURGERIES:

_____
_____
_____
_____
_____

POSITIVE PERSONAL MEDICAL HX :

Diabetes_____
Heart Ds_____
COPD/Asthma_____
Thyroid Ds_____
Arthritis/Autoimmune_____
Hypertension _____
Cancer/CVA_____
Prematurity/Developmental_____
All Other Systems _____

MEDICAL DOCTORS:_____

MEDICATIONS

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES/REACTIONS:

_____
_____
_____

HIPAA PATIENT RECORD OF CONSENT

FOR

Marc Safran, M.D.
8340 Oswego Road
Liverpool, NY 13090
315-622-1234

Patient Name: _____ **Home phone: _____**

Date of Birth: _____ **Work phone: _____**

Cell phone: _____

___ I authorize the office to contact me regarding my private health care information via my home, work, or cellular telephone or by postal mail. I authorize the office to leave a message with detailed information on any or all of my answering machines, voicemail or with my alternate contact person(s) listed below.

___ I authorize the office to release my private health care information in the following capacities:

1. **Provide reports to my referring doctors**
2. **Provide reports to specialists I may be sent to for further care**
3. **The exchange of information with pharmacies regarding my medications**
4. **The transmission of information needed to bill my insurance company**
5. **Provide glasses and contact lens prescriptions to my optician/optical shop**
6. **Notify me or my alternate representative of eyeglass orders I have at the office**
7. **Notify me of office appointments or billing matters**

I authorize the following alternate contact person(s) permission to talk with a representative from the office.

Name: _____

Relationship: spouse, mother, father, son, daughter, mother-in-law, father-in-law, sister-in-law, brother-in-law, relative, friend, other _____

Telephone number(s): _____

___ I authorize no alternate contact person to have access to my private health care information.

Patient Signature: _____ Date: _____

CLAY EYE CENTER

8340 Oswego Road Suite 225/Liverpool, NY 13090

This form acknowledges that as your eye care provider, our relationship is with you, not your insurance company. While our filing claims to your insurance company is a courtesy which we extend to our patients, all charges are your responsibility from the date that services are rendered. Insurance benefit plans vary widely, not just from insurance carrier to different insurance carrier, but also within the same company. This practice recommends that you contact your insurance company directly to become familiar with your benefits. Your insurance carrier will also be able to advise you if you need a referral for your visit. We do not participate with and can not bill services to any vision insurance companies such as VSP, Davis Vision, or Spectera.

Statement of Financial Responsibility

I certify that I am responsible for my account in its entirety including, but not limited to, deductibles, coinsurance, copayments, and other non-covered services.

I certify that if I fail to provide or refuse to provide information necessary to process my insurance claims that I am responsible for the entire amount of my bill including amounts that usually would have been paid by my insurance carrier.

I certify that in the event that my account gets assigned to collection for nonpayment, I agree to pay the collection company's $15 processing fee.

SIGNATURE:_____DATE:_____

Statement Authorizing Payment of Insurance Benefits

I hereby assign my medical/surgical benefits and I authorize my insurance carriers to make payment directly to Clay Eye Center for medical and surgical services rendered. This is a lifetime assignment; it can be canceled in writing at any time.

SIGNATURE:_____DATE:_____

PEDIATRIC PATIENTS ONLY

I certify that I am responsible for my child's account. I understand that any bills will be sent to me and that it is not the policy or responsibility of The Clay Eye Center to send bills to another parent if there is a divorce situation.

PARENT NAME:_____

SIGNATURE:_____DATE:_____

MEDICARE PATIENTS ONLY

Statement Authorizing Payment of Medicare Benefits.

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to: Marc Safran, M.D.

SIGNATURE:_____DATE:_____

Medication and Allergy List

Medication :	Dose (mg):	Frequency:

Allergies:	Type of Reaction