Brimhall eye

Brimhall Eye Patient Registration Form

Patient Information			
Last Name:	First Name:	Preferred Name:	Sex: ☐M ☐F
Date of Birth:	Patient SSN:	How did you hear about us?	
Home Phone:	Cell Phone:	Email:	
Preferred Contact for Appointment Reminders: ☐Text Message ☐Phone Call ☐ Email			
Address:			
City:	State:	Zip Code:	
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	Spouse Name:		
Employer:	Occupation:		
Pharmacy Name:	Pharm. Cross Streets:	Eyeglasses Doctor:	Primary Care Physician:

Primary Insurance Information			
Insurance Company Name			Effective Date
ID Number:	Group Number:		Plan Type: ☐HMO ☐PPO ☐Other
Name of Subscriber/Policyholder			Relation: ☐Self ☐Spouse ☐Parent ☐Other
SSN	DOB:	Sex: ☐Male ☐Female	Employer
Secondary Insurance Information (If applicable)			
Insurance Company Name			Effective Date
ID Number	Group Number:		Plan Type: ☐HMO ☐PPO ☐Other
Name of Subscriber/Policyholder			Relation: ☐Self ☐Spouse ☐Parent ☐Other
SSN:	DOB:	Sex: ☐Male ☐Female	Employer:

Responsible Party Information (If patient is a minor, for example, Parent/Legal Guardian Information)		
Last Name	First Name	Sex: ☐Male ☐Female
Address		
Home Phone	Cell Phone	Email
SSN	DOB	Relation to Patient:

Emergency Contact Information	
Name:	Relation
Primary Phone:	Alternative Phone:

Legal Representation / Power of Attorney

☐ **I am the patient** and I have filled out the information to the best of my knowledge. I understand that if any information changes, I will notify Brimhall Eye before my next visit.

Patient Signature **Date**

☐ **I am NOT the patient** and I have filled out the information to the best of my knowledge. By signing and filling out these forms, I understand that I must have Power of Attorney over this patient. I understand that I must provide the legal documentation at the time of the visit. Failure to provide documentation may result in appointment cancelation.

Power of Attorney Signature **Date**

Relationship to patient _____

Office Visit Summary

Brimhall Eye is committed to providing their patients with education and understanding of their eye health.
We offer to our patients a summary of their office visit as they check out.
Brimhall Eye does not discriminate based on race, age, sex, or ethnicity.

Background Information

Due to legislation changes, the government is requiring medical facilities to collect the following information.

Please Circle all that applies

Ethnicity/Race		Primary Language Spoken	
American Indian	Alaska Native	Chinese	Spanish
Black or African American	Native Hawaiian	English	Russian
Hispanic/Latino	Pacific Islander	German	French
White/Caucasian	Other:	Japanese	Other:

Last Name	First Name	Date of Birth

Patient Responsibility and Office Policy

Initials _____ Treatment of Staff: Any patient who acts in any way disruptive or abusive towards the staff will be discharged from the practice.

Brimhall Eye does not prescribe glasses or contact lens prescriptions. We will refer you out to a trusted Optometrist. All refractions done in office are for diagnostic purposes only. Refractions: a refraction is the portion of the examination process wherein the doctor or technician places various lenses in front of your eyes to determine your best corrected vision

Brimhall Eye charges a fee of $25 for any forms that need to be filled out by our physicians or staff. Forms will be completed within 5 business days and payment is due upon drop off.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency) so that we may open your reserved time for another patient. **Failure to notify our office will result in a $50 no-show fee.**

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, testing services and any other screening ordered by the doctor or staff. Payment is expected in full at the time services are rendered. Professional fees, services fees, copayments, and deductibles are NOT refundable. There will be a $25 fee for returned checks.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. You have the option to reschedule to obtain the proper referral on file.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

I understand that I need to provide a copy of my insurance card/s and photo ID. It is your responsibility to notify the office of secondary insurance coverage. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I hereby authorize my insurance benefits be paid directly to the facility. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. I authorize BE to send me notices, both reminders and promotional via email and text. BE provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient/Guardian/Responsible Party **Date**

Last Name	First Name	Date of Birth

HIPAA Approved Contacts

☐ Check here if you **do not** give your consent to release information to anyone.

☐ Check here if you are granting permission to release your records and health information to designated individuals.

- List approved individuals below:

Name	
Telephone	
Relationship	
Information	

Name	
Telephone	
Relationship	
Information	

Name	
Telephone	
Relationship	
Information	

Name	
Telephone	
Relationship	
Information	

I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely unless revoked in writing.

_____ _____

Patient/ Legal Guardian/Responsible Party Signature **Date**

Relationship to patient _____

(i.e., patient is a minor)

American with Disabilities Act Consent

If an interpreter is necessary, I give permission to the interpreter to transcribe my health history and information to the assigned physician of Brimhall Eye at the time of service. I understand this does not give the interpreter any right to the use or disclosure of my PHI.

_____ _____

Patient/ Legal Guardian/Responsible Party Signature **Date**

Relationship to patient _____

(i.e., patient is a minor)

NOTICE OF PRIVACY PRACTICES

Our office is committed to protecting the privacy rights of our patients and the confidential information entrusted to us. The dedication of each employee to ensure that your health information is never compromised is of paramount importance in our practice. We amend our privacy practices, but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Nevada. This includes issues relating to your treatment, payment and our health care procedures. Your personal health information will never be given to anyone without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic system are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality ophthalmic care, implement payment activities, conduct normal health practice procedures and comply with the law. This may include your name, address, telephone number(s), social security number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, e-mails, text messages and postcards.

PATIENT RIGHTS

You have a right to request copies of your healthcare information and to request a list of instances in which we or our business associates have disclosed your protected information. All such requests must be in writing. We may charge for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also contact the U.S. Department of Health and Human Services. We thank you for being a patient in our office. Please let us know if you have any questions concerning your privacy rights and the protection of your health information.

I hereby acknowledge that I have been presented this Notice of Privacy Practices

_____ _____

Patient/Guardian/Responsible Party **Date**

_____

Printed Name

Empathy · Integrity · Accountability · Joy · Synergy

Last Name	First Name	Date of Birth

Brimhall Eye Medication Form

Please list all of the medications that you are currently taking:
Please list all of your medication related allergies:

Patient/ Legal Guardian/Responsible Party Signature **Date**