CENTER EYE CARE

162 Park Street, Suite 201
North Reading, MA 01864
www.centereyecare.com

Patient Registration Form

Patient's Last Name:		First Name:	MI:
Date of Birth:	Age:	Sex: □ M □ F	Prefix: □ Mr. □ Mrs. □ Dr. □ Ms. □ Miss
Last 4 of SSN:		Occupation:	
Home Phone #:		Cell Phone #:	
Street Address:		City, State, and ZIP Code:	
Email Address:		Preferred Method of Contact: □ Home Phone □ Cell Phone □ Email	
Primary Care Physician:		Primary Care Physician's Address:	
How did you hear about our office? □ Insurance Plan □ Drive By □ PCP □ Google □ Yelp □ Family/Friend: _____ □ Other: _____			

Health Insurance Information

Name of Insurance Company/Carrier:		Policy Number/ID:
Person Responsible for Bill:		Primary Phone Number:
Address (if different):		Insurance Subscriber's Name:
Subscriber's DOB:	Subscriber's SSN:	Patient's Relationship to Subscriber: □ Self □ Child □ Spouse □ Other: _____

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Vision Insurance Information

(If Applicable)

Name of Vision Insurance Plan:		
Vision Insurance Subscriber's Name:	Subscriber's DOB:	Subscriber's SSN:
Policy Number/ID:	Patient's Relationship to Subscriber: □ Self □ Child □ Spouse □ Other: _____	

Insurance Policy

Up to date insurance information is required at the time of the visit. If insurance information is not accurately disclosed, the patient will be responsible for any fees incurred. Professional fees are non-refundable and are ultimately the patient's responsibility. If you will need a referral for your visit, please obtain that referral before your visit or you will not be covered and billed accordingly. Understanding insurance benefits is ultimately the patient's responsibility.

I have read, understand and agree to the above policy.

Patient/Guardian Signature: _____

Date: ____/____/_____

Assignment of Benefits

I request that payment of authorized and assigned insurance be made directly to Center Eye Care for any services rendered. I authorize this holder of medical information about me to release to CMS and necessary agents any information to determine these benefits payable for related services.

Patient/Guardian Signature: _____

Date: ____/____/_____

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Notice of Privacy Practices

I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Patient/Guardian Signature: _____

Date: ____/____/_____

Optomap Retinal Screening vs. Dilation

Optomap Photos

This is a retinal screening utilizing revolutionary technology that allows our doctors to view a majority of the retina (82% or 200 degrees). A high-resolution image is captured in seconds – without dilation. The screening is very easy for the patient, takes only a few moments and is available for immediate review with patient.

THIS IS AN ELECTIVE PROCEDURE.

The fee for this procedure is $39.

Dilation of the Pupils

This is the traditional method utilizing eye drops and will result in blurred vision (mostly near vision) for about 4-6 hours. The drops cause the pupil to dilate so the clinician may see the retina (inner layer of the eye). This involves the utilization of a light source and magnifying lens to evaluate the entirety of a patient's retina.

Select One

□ I **do** wish to have the Optomap Retinal Exam.
By checking this box, I realize am responsible for the $39 charge.

□ I **do not** wish to have the Optomap Retinal Exam. By checking this box, I realize I will not be having the Optomap Retinal Exam and drops will be used to dilate my pupils as part of my comprehensive eye exam. Dilating drops may affect my vision and make driving and reading difficult.

Patient/Guardian Signature: _____

Date: ____/____/_____

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Patient Authorization to Release Healthcare Information

Patient Name: _____

Date of Birth: ____/____/_____

I authorize Center Eye Care to release the entirety of my medical record, including my glasses or contact lens prescriptions to the following:

Doctor or facility's name _____
Address _____
_____
_____
Facility's Fax number _____
Email _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rules. I have the right to revoke this authorization in writing except to the extent that the covered entity has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the covered entity.

Expiration date, if applicable: ____/____/_____

Reason for request:
Insurance/Second opinion/Moving/Other: _____

Patient/Guardian Signature: _____

Date: ____/____/_____