PATIENT REGISTRATION SHEET

Patient's Last Name _____

Patient's First Name _____

Address _____

City _____

State _____ Zip _____

Cell Phone ( ) _____

Home Phone ( ) _____

Patient's S.S. # _____

Patient's Sex: ( ) Male ( ) Female Age _____

Patient's Marital Status: S M W D

Patient's Date of Birth: _____/_____/_____

Patient's Occupation _____

Patient's Employer _____

Business Address _____

City _____

State _____ Zip _____

Work Phone ( ) _____

Who was your previous eye care Provider? _____

How did you learn about us? _____

_____

E-Mail Address _____

Emergency Contact & Phone # _____

_____

Responsible party if other than Patient _____

Patient's relationship to responsible party _____

Responsible Party S.S. # _____

Home Address _____

City _____

State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone ( ) _____

Responsible Party Date of Birth: _____/_____/_____

Responsible Party Employer _____

Address _____

City _____

State _____ Zip _____

RELEASE OF INFORMATION

I hereby give consent to the attending physician to release my information acquired in the course of examination or treatment and allow a photocopy of my signature to be used for insurance purposes only. I give permission to release medical records or information to other medical doctors.

_____

DATE SIGNATURE OF PATIENT

CLAIM PAYMENT AUTHORIZATION

The subscriber hereby gives consent for his/her insurance company(s) at its option to issue indemnity checks to the provider rendering services.

_____

DATE SIGNATURE OF PATIENT

Harper's Point Eye Associates
8211 Cornell Road
Cincinnati, Ohio 45249
(513) 530-0440

FINANCIAL POLICY AND PATIENT RESPONSIBILITY

We at Harper's Point Eye Associates are eager to help you make optimal use of all your insurance coverage. However, with the growing complexities of insurance policies today, and the constant changes being made by insurers and employers, keeping up to date is difficult. While our office tries its best to keep current with the developments in the health insurance area, the ultimate responsibility of knowing the specifics of YOUR particular policy must remain with YOU. If you have any questions pertaining to your coverage, CALL YOUR INSURANCE CARRIER. This may include questions regarding exam fees, co-payments, contact lens professional fees, glasses and contact lens material fees.

You, as the patients, are ultimately responsible for all fees. We do accept insurance assignment and will file your claim for you; however, you are still responsible for all co-payments or balances as required by your specific insurance plan. You are required to bring your insurance card to each visit. All co-payments and co-insurance are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary co-payments, co-insurance and deductibles.

Acceptable methods of payment include cash, check, bankcard or credit card (Visa, MasterCard, American Express, or Discover).

_____ _____/_____/_____
Patient signature Date

Acknowledgement of Receipt of Notice of Privacy Practices
(Please sign this section when you register for your visit.)

I acknowledge that I have received a copy of Harper's Point Eye Associate's Notice of Privacy Practices.

_____ _____/_____/_____
Signature of patient/patient representative Date

_____ _____/_____/_____
Relationship to patient Date