CENTER FOR SIGHT
PATIENT REGISTRATION

PATIENT INFORMATION (PLEASE PRINT)

Patient Name _____ Date _____
Last First Initial

Address_____
Street City State Zip

Social Security # _____ Sex: □Male □Female

Birth Date _____ Birth State_____

Occupation _____ Employer _____

Marital Status (Circle One): Single Married Widowed Divorced

Communication:
□Home Phone _____ □Work Phone _____Ext _____

□Cell Phone _____/Carrier_____

□Email address _____
Please mark preferred communication method

Primary Language_____

Race: □American Indian or Alaska Native
□Asian
□African American
□Native Hawaiian or other Pacific Islander
□White

Ethnicity: □Not Hispanic or Latino
□Hispanic or Latino

Who may we talk to about your medical concerns:

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Full Name_____

Occupation _____ Employer_____

Home Phone _____ Work Phone _____ Ext _____

Social Security # _____ Sex: M F Birth Date_____

OTHER INFORMATION

In case of emergency _____ Phone Number _____

Relationship _____

Referred to this office by Yellow Pages Doctor (Name) _____
Newspaper Friend _____
Other_____

ACCIDENT

Accident related to **WORK** Y N **AUTO** Y N **OTHER** Y N

Date of Accident and Brief Description of Injury and Circumstances

_____

_____

INSURANCE AUTHORIZATION
& PAYMENT AGREEMENT

I hereby authorize Center For Sight, Inc. to furnish information to my insurance carriers (if any) concerning my diagnosis and treatment and hereby assign to Center For Sight, Inc. all payments for medical services rendered to myself or my dependents.

I understand that I am responsible for any amount not covered by insurance. You agree to reimburse Center For Sight the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Date_____

Signature_____

CENTER FOR SIGHT
PATIENT PRIVACY CONSENT FORM

Center For Sight, Inc. has always been committed to maintaining patient confidentiality. We appreciate this opportunity to clarify our privacy practices for you as a result of the Health Insurance Portability and Accountability Act of 1996.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required by law to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Center For Sight provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- Center For Sight has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Center For Sight reserves the right to change the Notice of Privacy Policies
- The patient has the right to request limitations and restrictions of their personal health information
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Center For Sight may condition treatment upon the execution of this Consent

This Consent was signed by: _____

Signed Name Printed Name

Relationship to Patient (if other than patient):_____

Date:_____

In front of _____

Practice Representative

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: