The Laser Eye Institute

1603D MEDICAL DR.
LAURINBURG NC 28352
910-277-1411-Phone 910-277-2911-Fax

ACCT #_____

PATIENT REGISTRATION FORM

PLEASE COMPLETE ALL SECTIONS ON FRONT & BACK

SECTION 1: BASIC PATIENT INFORMATION

Patient's FULL name:		EMAIL:	Marital status (circle one) Single / Mar / Div / Wid

Race: *(circle ALL that apply)* White/ Black/ Asian/ Other American Indian/ Decline	Ethnicity: *(circle one)* ARE YOU HISPANIC? YES/ NO/Decline	GENDER: (Circle One) Male/ Female Decline	Date of Birth: __/__/____	Social Security #: ___-___-____

COMPLETE Mailing Address:		Primary language: (CIRCLE ONE) English/Spanish Other/Decline	2 Phone no :

Primary Dr/Office Name:	Pharmacy Name:	Pharmacy Location:

SECTION 2: EMERGENCY CONTACT PERSON ONLY *ADD TO HIPPA (IN SECTION 3) IF WE CAN SPEAK TO HIM/HER....*

Name:	Relationship to patient:	Phone no.:	another way to contact:

SECTION 3: PROTECTED HEALTH INFORMATION RELEASE FORM (HIPPA):

Concerning any/all matters of my health, I give permission for Dr. Jute and/or any member of his staff to speak with any of the following people listed below. This may include picking up any notes, Rx's, speaking to the staff on the telephone, and/or any other matters deemed necessary.

Name of person(s):_____ Relationship & phone #:_____
Name of person(s):_____ Relationship & phone #:_____
Name of person(s):_____ Relationship & phone #:_____
Name of person(s):_____ Relationship & phone #:_____

SECTION 4: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician for any medical/surgical procedure(s) performed. I understand that I am financially responsible for any balance. I also authorize THE LASER EYE INSTITUTE or insurance company to release any information required to process my claims.

Patient &/OR Guardian SIGNATURE: **Date:**

SECTION 5: COMPLETE THIS LINE ONLY IF UNDER 18

Parent/Guardian FULL NAME & DOB:	

CONSENT FORM:

(For use & disclosure of Protected Health Information for Treatment/Payment/Healthcare Operations)

I understand that as part of my healthcare, The Laser Eye Institute (TLEI) originates and maintains health records describing my health history, symptoms, examinations, test results, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis & surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality & reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses & disclosures. I understand & have the right to review the notice prior to signing the consent. I understand the practice reserves the right to change their notice & practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information (PHI). I also understand that I have the right to restrict as to how my PHI may be used to disclosed to carry out treatment, payment, and/or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With this consent, TLEI may call to my home or other designated location and/or leave message on my voicemail, e-mail, and/or with a person in reference to any items that assist the practice in carrying out treatment, payment, and/or operation (TPO), such as appointment, reminders, insurance items, and/or any call pertaining to my clinical care, including laboratory results among others.

I have the right to request that TLEI restrict how it uses or discloses my PHI to carry our TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to TLEI to use and/or disclose my PHI to carry out my TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, TLEI may decline to provide treatment to me.

HIPPA COMPLIANCE STATEMENT:

At TLEI we are dedicated to protecting your medical information. We are required by law to maintain the privacy of PHI and to provide you this notice of our legal duties and privacy practices with respect to PHI. TLEI is required by law to abide the terms of this notice. We comply with all federal, state, and local laws. This notice describes how we use your PHI. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit our office(s), we record your symptoms, physical examination, test results, diagnosis, and/or treatment. This information enables us to: planning of your care, communicate with others for you, report to your insurance carrier, bill for our work, and/or improve the quality of care.

YOUR RIGHTS:

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a fee, and tell us not to release information upon a written request. Any patient/guardian/representative may file a complaint to the practice and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact TLEI, 1603D Medical Drive, Laurinburg, NC, 28352. By phone, 910-277-1411, or by fax, 910-277-2911. All complaints will be addressed and the results will be reported to the privacy officer.

OUR RESPONSIBILITIES:

We are required to: maintain the privacy of your PHI, send needed PHI to other medical providers, release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED:

Your PHI will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals and/or businesses. Examples include but not limited to other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard you information.

OTHER NOTICES:

We may leave a message at your home, on your answering machine/voicemail. We may mail you a written notice. We may need to disclose your information to your family members and/or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your PHI to your workers compensation insurance company. We may, from time to time, update these policies.

FINANCIAL POLICY:

I authorize the release of any and/or all medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, applications, and/or prescriptions. I also authorize payment of benefits to TLEI. I understand that I am financially responsible for all services rendered for the following reasons: I do not have the proper referral prior to to the time of service. My referral is invalid/expired. I have given incorrect/invalid insurance information. Expenses are not covered by my insurance company. I have not met my deductible. The services rendered are deemed medically unnecessary by my insurance company. (This applies to present and/or future visits).

*Payment is required **up front** for all services that are rendered. This includes co-payments and all outstanding balances. The signature below signifies you understand and are willing to comply with the policies of this office, your insurance plan, HIPPA and all PHI.*

*Signature:_____ Date:_____