PATIENT REGISTRATION FORM

TODAY'S DATE _____ PLEASE PRINT CLEARLY

DEMOGRAPHICS

_____ _____ _____ Mr. Ms. Mrs. Other _____
LAST NAME FIRST NAME MIDDLE NAME SALUTATION: CIRCLE ABOVE, OR SPECIFY

_____ _____ _____ Female Male Non-binary
NICKNAME PREFERRED PRONOUNS SOCIAL SECURITY NUMBER GENDER: CIRCLE ABOVE TO MATCH INSURANCE*

_____/_____/_____ _____ ☐ Interpreter needed
BIRTH DATE PRIMARY LANGUAGE

We are committed to creating a welcoming and respectful environment; please let us know your preferred pronouns or other manner of address.

_____ _____ _____
STREET ADDRESS PO BOX CITY, STATE, & ZIP CODE

_____ _____ _____
PRIMARY PHONE WORK PHONE CELL PHONE

_____ _____ _____
E-MAIL ADDRESS PRIMARY CARE PROVIDER LOCATION (CITY, STATE)

_____ _____ _____
EMERGENCY CONTACT PHONE NUMBER GUARDIAN (IF APPLICABLE)

INSURANCE INFORMATION

_____ _____ ☐ Vision Plan? _____
PRIMARY INSURANCE SECONDARY INSURANCE

_____ _____/_____/_____ _____
PERSON RESPONSIBLE FOR BILL BIRTH DATE PHONE NUMBER

_____ _____ _____
STREET ADDRESS PO BOX CITY, STATE, & ZIP CODE

PRIVACY PRACTICES

I acknowledge that I have been advised of Eye Physicians of Northampton's Notice of Privacy Practices (copies are in waiting room for your viewing). I authorize the release of any medical information necessary to process claims for all visits. I request payments be made payable and addressed to Eye Physicians of Northampton. I understand I am responsible for the payment of any non-covered service or any service/procedure that is applied to an annual deductible and for getting any insurance referrals necessary for service/procedures provided by this office on the specified date(s) of service.

NO-SHOW AND LATE CANCEL POLICY

I acknowledge that I have been advised of Eye Physicians of Northampton's "No-Show" and Late Cancel Policies:

- Patients are required to call or leave a message to cancel an appointment **at least 24 hours** prior to their appointment.
- Failure to cancel at least 24 hours prior to a scheduled appointment will be considered a "No-Show" or a Late Cancellation and **subject to a $50 fee** which must be paid prior to or upon arrival for the next appointment.
- In the event of three (3) documented "No-Show" or Late Cancellations, the patient **may be subject to dismissal from the practice**.

_____ _____
SIGNATURE OF PATIENT (OR GUARDIAN) TO ACKNOWLEDGE **BOTH** OF THE ABOVE POLICIES DATE

RELEASE OF INFORMATION

I authorize Eye Physicians of Northampton to use, review, give, disclose, and release the health, medical, and mental health information and related records for the patient named above, to the recipient(s) named below. Method of release shall be pertinent to the need and may include photocopies, photographs, tax copies, scanned copies, postal mail, express mail, computer files, email, telephone, electronic, or verbal communications. This release applies to any individually identifiable health information (Protected Health Information) governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____ _____
NAME(S) PHONE RELATIONSHIP