Rosin Eyecare Confidential Internal Patient Registration Form

First Name:_____

Last Name:_____

Daytime Phone: (_____)_____

Mobile Phone: (_____)_____

Date of Birth:_____/_____/_____

Gender Identity:_____

Email Address:_____

Street Address_____

Apt/Unit_____

City_____

State_____

Zip_____

Occupation:_____

Rosin Eyecare and Comprehensive Eyecare Physicians Fax and Email Request Authorization

I understand that you will be transmitting my medical records electronically and authorize you to do so. If another party received my medical records in error, I absolve Rosin Eyecare & Comprehensive Eyecare Physicians of any and all liability to such submission of said records.

Please FAX my medical records to: (_____)_____

Please EMAIL my medical records to: _____

This email release pertains to the patient or guardian as well as any outside party authorized by the patient. If you would like your records/Rx emailed to you, please provide your email address in this section.

Guardian Information (If different from the patient)

First Name:_____

Last Name:_____

Relationship to Patient:_____

Emergency Contact
Name:_____
Phone #: (_____)_____-_____

Vision Insurance

Provider Name:_____

Member ID #: _____

Policy Holder Name:_____

Policy Holder D.O.B.: ___/_____/_____ Last 4 SSN: _____

Medical Insurance

Provider Name:_____

Member ID #: _____

Policy Holder Name:_____

Policy Holder D.O.B.: ___/_____/_____ Last 4 SSN: _____

Financial Responsibility Statement

In an effort to serve you efficiently, we have instituted the following financial policy. Our office will, as a courtesy, file insurance claims based upon the information you have provided us, if we are a participating provider in your insurance plan. It is your responsibility to provide us with complete and accurate information. You will be asked to provide this information on an annual basis. Failure to provide information necessary and required by your insurance company will result in denial of your claim. Insured parties are expected to know their plan requirements and abide by any specifications of their insurance plan. Furthermore, if your insurance company requests information from you, you must provide that information promptly. If your claim is denied, it becomes your responsibility to pay the balance in full. By signing below, you understand that you will be responsible for payment of any services not paid by your insurance company which included co-payments, deductibles, coinsurance and non-covered items, and denied services not covered by contract between our office and your insurer. In instances where it is deemed necessary, we reserve the right to refer uncollected balances to an outside collection agency.
Rosin Eyecare requires that all exam fees and copays be paid in full at time of service, and a deposit of 50% when ordering materials.
By signing below, I agree that I am ultimately responsible for payment of services provided to me. My signature below authorizes Rosin Eyecare to release the information necessary to facilitate the payments of eyecare claims.

Continue on Other Side

Acknowledgement of Receipt of HIPAA Privacy Practices

I acknowledge that I received a copy of Rosin Optical Co., Inc. /Comprehensive Eyecare Physicians, P.C., Notice of Privacy Practices.

Date _____/_____/_____

Patient name_____

Signature _____

Consent for Verbal Release of Information

Type (please circle) **Leave Detailed Message**

Primary Phone Number: _____ **Home Work Cell** **Yes No**

Secondary Phone Number: _____ **Home Work Cell** **Yes No**

Please list any persons with whom we MAY share details about your health care. Indicate whether this may include private health information (PHI) such as exam results, billing questions or other health information.

Name	**Relationship**	**Release PHI?**
_____		**Yes No**
_____		**Yes No**

I understand that this consent is valid until revoked by me and applies to information about me obtained through any and all Rosin Eyecare locations and doctors. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the doctor. I also understand that I will not be able to revoke this consent in cases where the doctor has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the doctor's office.

Refund Policy

You can return your eyeglasses for a full refund within 30 days of the pick-up date. This applies to original purchase. Does not cover accidental damage, scratches, breakage, or theft. You can return your contact lenses for a full refund within 30 days of pick-up or delivery to your home as long as the boxes are unopened, undamaged and not written on. Exam fees cannot be refunded and insurance benefits cannot be reinstated.

Exchange Policy

Eyeglasses may be exchanged within 30 days of pickup. Eyeglasses exchanged for a higher frame or lens cost must be paid at time of exchange. Any difference in price on an eyeglass exchange is not refunded due to the custom nature of product.

Contact lenses may be exchanged within 30 days of pickup. Boxes must not be opened, damaged or defaced in any way. Exchanges that result in a higher cost must be paid at time of exchange. Exchanges that result in a credit back will be left on account to be used at a later date.

Signature agreeing to all terms detailed above: _____

Printed Name: _____

Date: _____

Reviewed: Initials_____ Date_____ Initials_____ Date_____ Initials_____ Date_____ Initials_____ Date_____