

## Rosin Eyecare Confidential Internal Patient Registration Form

First Name: _____ Last Name: _____ Daytime Phone: (____) _____ Mobile Phone: (____) _____ Date of Birth: ____/____/____ Gender Identity: _____	Street Address _____ Apt/Unit _____ City _____ State _____ Zip _____ Occupation: _____
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### 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. To ensure that we can email your records/Rx to you, please provide your email address above.

### Guardian Information (If different from the patient)

First Name: _____ Last Name: _____ Relationship to Patient: _____	Emergency Contact Name: _____ Phone #: (____) _____ - _____
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#### Vision Insurance

#### Medical Insurance

Provider Name: _____ Member ID #: _____ Policy Holder Name: _____ Policy Holder D.O.B.: ____/____/____ Last 4 SSN: _____	Provider Name: _____ Member ID #: _____ Policy Holder Name: _____ Policy Holder D.O.B.: ____/____/____ Last 4 SSN: _____
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### 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: \_\_\_\_\_ HomeWork 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?	
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		Yes	No
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		Yes	No
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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.

Signature agreeing to all terms detailed above: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed: Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_