Patient Registration

Please Print

Patient: _____ **Home Phone:** _____
First Middle Last

Address: _____ **Work Phone:** _____

_____ **Cell Phone:** _____
City State Zip

Preferred Contact: ☐ *phone* ☐ *text* ☐ *email* ☐ *mail* **Email:** _____

Age: _____ **Birthdate:** _____ **Patient SS#:** _____ **Sex:** ☐ *Male* ☐ *Female*

Employer: _____ **Occupation:** _____

Spouse: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Loss of Which Eye: ☐ *Left* ☐ *Right* **Date of First Eye Surgery:** _____ **Most recent:** _____

Reason for Loss of Eye: _____ **Date of Loss:** _____

Primary Care Physician: _____ **Phone:** _____

Ophthalmologist: _____ **Phone:** _____

How did you hear about us? _____

If referred by a physician, who? _____ **City:** _____

Do you have any medical conditions/allergies we should be aware of? _____

_____

Insurance Information

Primary Insurance: _____

Subscriber: _____

ID #: _____

Group #: _____

Subscriber's Employer: _____

Subscriber's Birthdate: _____

Subscriber's SS#: _____

Patient's Relationship to Subscriber:
☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Dependent*

Additional Insurance: _____

Subscriber: _____

ID #: _____

Group #: _____

Subscriber's Employer: _____

Subscriber's Birthdate: _____

Subscriber's SS#: _____

Patient's Relationship to Subscriber:
☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Dependent*

Assignment and Release

Payment is due upon delivery of services. As a courtesy, we will bill your insurance for you.

I hereby authorize my insurance and government benefits be paid directly to Erickson Labs Northwest. I am financially responsible for any balance due, and agree to pay this upon delivery of services. If the insurance company sends the checks for my services directly to me, I will immediately make the full amount payable to Erickson Labs Northwest for services rendered. I authorize release of any photographs taken as part of my medical record. I also authorize Erickson Labs Northwest to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____ **Relation to Patient:** _____

ERICKSON LABS NORTHWEST, LLC
HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: September 27, 2012

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your ocularist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (*full Notice is available upon request*)

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the office manager to file a complaint.

Acknowledgement of Receipt of this Notice: We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

ERICKSON LABS NORTHWEST, L.L.C.

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We keep a record of the heath care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Office Manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my Signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

This form will be retained in your medical record.

Last Update: January 13, 2012