EYE SITE OF CRESTVIEW, P.A.
DR. CHRISTOPHER HOWARD

DATE: _____ **PERSONAL REGISTRATION INFORMATION** **PLEASE PRINT CLEARLY**

PATIENT INFORMATION

NAME: _____ AKA: _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER: _____ GENDER: M F MARITAL STATUS: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

OCCUPATION/EMPLOYER: _____ DRIVERS LICENSE NO. _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____

RACE: _____

INSURANCE

PRIMARY INSURANCE CO: _____ PHONE NO: _____

INSURED NAME: _____ INSURED DOB: _____ SS# _____

PLAN TYPE: _____ GROUP #: _____ INSURED ID #: _____

INSURED DRIVERS LICENSE NO: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CO: _____ PHONE NO: _____

INSURED NAME: _____ INSURED DOB: _____ SS# _____

PLAN TYPE: _____ GROUP #: _____ INSURED ID #: _____

INSURED DRIVERS LICENSE NO: _____ RELATIONSHIP TO PATIENT: _____

HOW MAY WE CONTACT YOU?

HOME PHONE: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

WORK PHONE: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

CELL PHONE: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

EMAIL: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

The more available you are to us, the more quickly we can provide you with important scheduling changes, visit reminders, labaratory results, peri-operative instructions, answers to your questions, etc.

EYE SITE OF CRESTVIEW, P.A.
DR. CHRISTOPHER HOWARD

INFORMATION SHARING

NAME: _____ DATE: _____

PHARMACY / PHYSICIANS / HEALTH CARE PROVIDERS

We believe it is in your best interest for us to know all the health care providers involved in your care, so that we may communicate relevant information in a timely fashion. Please list below all of your regular physicians and health care providers (including complementary health care providers such as chiropractor, naturopath, dietician, and acupuncturist) with whom you are willing for us to communicate.

PROVIDER'S NAME	SPECIALTY	TELEPHONE NUMBER

FRIENDS AND FAMILY

Your privacy is very important to us. We can not share any information (including confirming appointment date and time) with anyone, including a spouse or care-giving child (unless they are your legal guardian) without your express permission. Please list below all persons with whom you will allow us to fully discuss your medical issues.

NAME	RELATIONSHIP	TELEPHONE NUMBER

LEGAL GUARDIAN

If you have appointed a legal guardian for your health and financial issues, please tell us who that is.

Guardian's Name: _____

X _____
Signature of Patient or Legal Guardian

EYE SITE OF CRESTVIEW, P.A.
DR. CHRISTOPHER HOWARD

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Thank you for selecting Eye Site of Crestview, PA (ESOC) for your care. To prevent any confusion over financial responsibility for medical and surgical services provided, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of services at the time of office visit, test, or procedure. Payment may be made by cash, personal check (NSF charge: $25), or credit card (American Express, Discover, VISA, or MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of service. Bills provided at each visit contain all the information needed for you to submit requests to your insurance carrier.

If your insurance plan requires a referral from your primary care physician, it is your responsibility to bring the referral with you and present it at the registration desk at the time of your visit. Federal law and insurance contracts require us to ask for your insurance card and driver's license to check in for identification purposes.

ESOC CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that has a contract with the doctor you are seeing, we are required to ask for a copy of your insurance card and payment of your deductible and/or co-payment at the time of service.

NON-ESOC CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that does not have a contract with the doctor you are seeing, we will ask for a copy of your insurance card but payment for services will be due at the time of your visit. We will be happy to file for your possible reimbursement.

MEDICAID

If you have Medicaid coverage, you must provide a current Medicaid card at the time of your visit. You must pay for non-covered services at the time of your visit.

MEDICARE

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the annual deductible for the calender year. You are fully responsible for any non-covered services. As a courtesy, if you have supplemental insurance, we will be glad to file this for you.

"I have read the above information and agree that regardless of insurance status, I am responsible for the account balance for all services rendered to the individual listed as "patient" below including disclosed, non-covered medical services. Further, I irrevocably assign and transfer all health plan and insurance benefits to Eye Site of Crestview, PA (ESOC), authorizing payment to ESOC for all benefits payable to "patient" including health plan benefits , ERISA benefits, insurance payments, payments pursuant to the Social Security Act and other medical benefits to ehich "patient" may be entitled. ESOC may pursue collection of such benefits in "patient's" name or in the name of ESOC. Finally, I authorize the release of medical information necessary to process "patient's" claims. A photocopy of this agreement shall be considered as effective and valid as the original."

Patient's Name (please print) : _____ Date:_____

Patient's Signature: X_____

If applicable, Signature of guardian or responsible party: X_____

Printed Name of guardian or responsible party: _____

EYE SITE OF CRESTVIEW, P.A.
DR. CHRISTOPHER HOWARD

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Eye Site of Crestview, PA (ESOC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ESOC. I understand that diagnosis or treatment of me by Christopher Howard, O.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ESOC is not required to agree to the restrictions that I may request. However, if ESOC agrees to a restriction that I request, the restriction is binding to ESOC and Christopher Howard, O.D.

I have the right to revoke this consent, in writing, at any time, except to the extent that Christopher Howard, O.D. or ESOC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review ESOC's Notice of Privacy Practices prior to signing this document. ESOC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the ESOC. The Notice of Privacy Practices for ESOC is also provided in the clinic entryway. This Notice of Privacy Practices also describes my rights and the ESOC's duties with respect to my protected health.

ESOC reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

Description of Personal Representative's Authority

Christopher R. Howard
Optometric Physician

Records Release Request

Date: _____

To: _____

_____

_____

_____

Patient: _____

DOB: _____

Please release my visual examination information to the office listed below.

Information requested:

- ☐ Spectacle Prescription
- ☐ Contact Lens Prescription
- ☐ Ocular Health Findings

Send information to:

Eye Site of Crestview, P.A.
1005 South Ferdon Blvd.
Crestview, FL 32536
Phone (850) 682-1859
Fax (850) 682-8674

Patient Signature: _____