Patient Registration
Barbara Bowers, M.D. PLLC

Today's Date: _____
Month / Day / Year

Name: _____ Social Security #_____
Last First MI

Address: _____ _____
Street City State Zip

Age: _____Date of Birth: _____ Male / Female Marital Status: S M W D Race_____ Ethnicity_____
Month / Day / Year

Please provide the following to allow us to communicate with you more efficiently:

Email_____ Cell Phone# _____Home #_____

Do you receive Text messages? YES or NO

Employed By: _____ Retired _____ Occupation: _____

Address: _____ Telephone: _____

Spouse or Parent's Name: _____Date of Birth_____

Relative not living with you: _____ Relationship: _____

Address: _____ Telephone: _____

Different person responsible for payment? _____ Relationship: _____

Address: _____ Telephone: _____

Date of Birth: _____ Social Security Number: _____

What is the name of your primary care physician? _____ M.D. D.O.

How did you hear about our office? Yellow Pages Friend Family Member TV Radio Billboard

Another patient, who? _____ Another doctor, who? _____

Emergency Contact_____

Health Insurance Information

Do you have health insurance? Yes No Medicare? Yes No **Your Medicare Number**: _____

If not Medicare, what is the name of your primary medical insurance? _____

Non-Medicare primary insurance policy holder's name: _____
Last First MI

Do you have secondary medical insurance? Yes No Secondary Insurance Name: _____

For billing purposes, our receptionist may wish to make a copy of your insurance plan cards

OFFICE FEE POLICY: ALL PAYMENTS ARE DUE AT TIME OF SERVICE

Insurance Assignment: I authorize release of Private Health Information for the purpose of obtaining payment from my insurance plan for all services rendered by Innovative Ophthalmology. I authorize payment directly to my provider and I understand that I am responsible for my bills if my insurance does not pay in full or does not cover rendered services. By signing below I have read and understand these statements.

SIGNATURE	**DATE**

HIPPA PRIVACY NOTICE TO OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so they may understand and comply with government rules and regulations regarding HIPPA, with particular emphasis on the "PRIVACY RULE". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the rules mandated by HIPPA. Our practice is determined not to contribute in any way to the improper disclosure of PHI. As part of this plan we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. However, it is necessary to routinely use PHI in the normal course of conducting a medical practice. Some examples of how we use your PHI include, but are not limited to: preparing and sending insurance claims and patient bills, referrals to other providers, requesting records from other providers, faxing or calling in prescriptions, sending appointment reminders or calling patients about appointments. We may also use PHI in collecting unpaid balances through another agency. However, any outside entity that we use also has a "Privacy Rule" plan in place and we have contracts with them to assure your PHI is secure. We will not disclose your PHI in any way, other than in the normal course of providing your eye care without your written permission, and if we request your permission for disclosure, you are not required to grant it. We will only discuss your treatment with you or your family and friends that assist you with your eye health care. If you prefer that we not leave messages for you on an answering machine or with a family member, please tell us and we will contact you directly. By signing the notice below, you acknowledge that we have provided you with information regarding our protection of your PHI.

I acknowledge that I was offered the opportunity to receive a copy of the Innovative Ophthalmology Notice of Privacy Practices. I also acknowledge that I agree to allow Barbara Bowers, MD, to use my PHI in any way necessary for treatment, consultation, payment from my insurance provider, or in preparing statements or reminders to be sent to me.

SIGNATURE	**DATE**