

BINGHAMTON EYE ASSOCIATES  
PATIENT REGISTRATION FORM

Date \_\_\_\_\_ Referred by \_\_\_\_\_ Family Doctor \_\_\_\_\_

PERSONAL INFORMATION

Name (Mr. Mrs. Ms.) \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M/F \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Spouse Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

RESPONSIBLE PARTY

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone# \_\_\_\_\_

INSURANCE INFORMATION

Primary Ins. Company \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber: \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Ins. Company \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber: \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_

Financial Agreement: I agree that in return for the services provided by Binghamton Eye Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Binghamton Eye Associates for payment. If an account is sent to collection, I agree to pay collection expenses and/or legal fees. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Binghamton Eye Associates. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Binghamton Eye Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Over ►

Signed (patient or parent, if minor) \_\_\_\_\_

### Patient Consent for Use & Disclosure of Protected Health Information

With my consent **Binghamton Eye Associates** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Binghamton Eye Associates' **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

I have the right to review the **Notice of Privacy Practices** prior to signing this consent. Binghamton Eye Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice may be obtained by forwarding a written request to **Binghamton Eye Associates, Privacy Officer, 33 Mitchell Ave. Suite 207, Binghamton, NY 13903.**

With my consent **Binghamton Eye Associates** may contact me by mail, phone and fax at my home or other designated location. in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements, messages pertaining to my clinical care. I have the right to request that Binghamton Eye Associates restrict how it uses or discloses my PHI. However, the practice is not required to agree to my request, but if it does, it is bound by this agreement.

By signing this form I am consenting to **Binghamton Eye Associates'** use and disclosure of my PHI to carry out treatment, payment and operations and **acknowledging receipt** of the Notice of Privacy Practices. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon by prior consent. If I do not consent to the use of information for treatment, payment and operations, **Binghamton Eye Associates** may decline to provide treatment to me.

Signed (patient or parent, if minor)

\_\_\_\_\_ Date \_\_\_\_\_

### MEDICARE LIFETIME ASSIGNMENT/SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to John F. Meehan, M. D. for any services furnished to me by Binghamton Eye Associates. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item (of the HCFA 1500 form or elsewhere on other approved claim forms), my signature authorizes releasing the information to the insurer or agency show. Binghamton Eye Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

\_\_\_\_\_  
Medicare Beneficiary or authorized Signature

\_\_\_\_\_  
Date