Swartz Family Eyecare, LLC
Patient Registration Form

Patient Information

Patient's First Name: _____ **Middle Initial:** _____ **Last Name:** _____
Date of Birth: ____/____/____ **SSN:** _____ **Email Address:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Phone: _____ ☐ **Cell** ☐ **Home**
Other immediate family members seen here: _____

Insurance/Billing Information

Name of Vision Care Plan: _____ **Name of Medical Insurance:** _____
Name of Secondary Insurance (if applicable): _____
Person responsible for insurance/bill: ☐ **Self** ☐ **Other (if other complete below)**
Name: _____ **Date of Birth:** ____/____/____
Address: _____ **Phone:** _____ ☐ **Cell** ☐ **Home**
Name of Insurance holder: _____ **Date of Birth:** ____/____/____ **SSN:** _____

Acknowledgement of Responsibility

The information provided on my medical insurance card and/or vision care plan card provided above are true to the best of my knowledge. When making a third-party claim, I authorize Swartz Family Eyecare, LLC to bill the medical insurance company and/or vision care plan on my behalf for any covered charges. I authorize the release of any medical information necessary for processing the claim. I also authorize my medical insurance company and/or vision care plan to pay insurance benefits on my behalf to Swartz Family Eyecare, LLC directly. I understand and agree that regardless of my medical insurance and/or vision care plan benefits, I (or my guarantor) am responsible to pay the balance on my account for all professional services and materials provided.

Patient/Legal Guardian Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of Swartz Family Eyecare, LLC's Notice of Privacy Practices. It tells me how Swartz Family Eyecare, LLC will use my Health Information for the purpose of my treatment and Swartz Family Eyecare, LLC's healthcare operations.

- The Notice explains in more detail how Swartz Family Eyecare, LLC may use and share my healthcare information beyond treatment, payment, and healthcare operations.
- Swartz Family Eyecare, LLC will also use and share my health information as required/permitted by law.
- I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Spouse _____ ☐ Child(ren) _____
☐ Other _____ ☐ Information is not to be released to anyone

Messaging Preferences:

Please call/text my ☐ Cell Phone ☐ Home Phone

If unable to reach me, please:

☐ Leave/send a message with information ☐ Leave/send a message asking me to return your call

Patient/Legal Guardian Signature: _____ **Date:** _____