Ruxton Towers Eye Associates

PATIENT REGISTRATION

NAME_____REFERRED BY_____
LAST FIRST MI

ADDRESS_____CITY_____STATE____ZIP_____

HOME PHONE _____SS#_____BIRTHDATE_____

WORK PHONE _____OCCUPATION_____

MARITAL STATUS S / M / D SEX M / F EMPLOYER or SCHOOL_____

EMAIL ADDRESS_____

GUARANTOR _____PHONE_____
(person responsible for payment)

INSURANCE_____NAME OF POLICY HOLDER_____

POLICYHOLDER BIRTHDATE _____POLICYHOLDER'S SS# _____

NAME OF PRIMARY CARE DOCTOR_____ PHONE_____

EMERGENCY CONTACT_____PHONE_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND ANY OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO RUXTON TOWERS EYE ASSOCIATES, FOR ANY SERVICES FURNISHED ME BY THESE PHYSICIANS/SUPPLIERS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS. ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT IF MY ELIGIBILITY CANNOT BE VERIFIED, DON'T OBTAIN THE PROPER REFERRAL FORM, ETC., I WILL BE FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED FOR SERVICES RECEIVED FROM THIS OFFICE.

OUR PRACTICE IS DEDICATED TO MAINTAINING THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION (PHI). WE ARE REQUIRED BY LAW TO MAINTAIN THE CONFIDENTIALITY OF PHI, WE ALSO ARE REQUIRED BY LAW TO PROVIDE YOU WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES. OUR PRACTICE HAS POSTED COPIES OF OUR CURRENT NOTICE IN OUR OFFICE AND YOU MAY REQUEST A COPY OF OUR MOST CURRENT NOTICE AT ANY TIME.

SIGNATURE_____DATE_____