FRANK EYE CENTER

Registration Form

Last Name:_____ First Name:_____ MI:_____

Address:_____City:_____ST:_____ZIP:_____

Home Phone:_____ Work/Cell:_____

Social Security #:_____ Employer:_____

Date of Birth:_____ Age: ____ Gender: (M/F)___Marital Status:_____

Ethnicity: African American Native American Asian Caucasian/White Hispanic Pacific Islander
Other No Reply
By what name do you wish to be called? _____
Primary Language: English Spanish Other: _____

Email: _____
Is this a medical condition due to an accident? Yes No If Yes, Date of Accident: _____

Name of Family physician: _____
If patient a minor:
Responsible Party _____ Relationship: _____ DOB:_____

INSURANCE INFORMATION:

Primary Insurance: _____

Name of Insured:_____ Insured Date of Birth:_____

Secondary Insurance: _____

Name of insured: _____ Insured Date of Birth: _____

Prescription Insurance: _____
I am responsible for any financial obligations if self-pay and or any after insurance has been considered and will make arrangements to see that those obligations are met. This serves as permission to file insurance on my behalf.
I have been offered and/or received a copy of Frank Eye Center's Notice of Privacy Practice.
Please circle **YES** or **NO**, then sign signature and date please.
Frank Eye Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language services are offered in the following languages: Spanish, Chinese, German, Korean, Laotian, Arabic, Tagalog, Burmese, French, Japanese, Russian, Hmong, Persian, Swahili. Please call 785-242-4242 if this needed.

_____ _____
Signature Date

_____ _____
Pt Representative Date

Frank Eye Center

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated

Patient Name: _____

SSN (last four digits): _____ Date of Birth: _____

Who will be authorized to receive/speak to regarding this information?

Individual Name: _____ Phone: _____
Relationship: _____

Individual Name: _____ Phone: _____
Relationship: _____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person or persons identified above:

( ) **ENTIRE PATIENT RECORD**

or, check only those items of the record to be disclosed:

( ) Office Notes
( ) Nursing home, home health, hospice, and other physician records
( ) Lab results, pathology reports
( ) Record of HIV & communicable disease testing
( ) X-rays
( ) Record of mental health or substance abuse treatment
( ) Financial history report (previous 3 years only)
( ) Only sent the following: _____

Purpose of Disclosure (please record the purpose of the disclosure of check patient request):

( ) Patient Request
( ) Other (please specify): _____

This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. FEC may determine a period of 2 years. You must renew or submit a new authorization after the expiration date of continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:

You have the right to terminate this authorization at any time by submitting written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient Signature Date

_____ _____
Patient Representative Signature Date