Eye Surgery and Laser Center
Dr. Anthony Novak

PATIENT INFORMATION Today's Date: _____

First Name_____ MI ___ Last Name_____

Date of Birth ____/____/____ age____ Sex M___ F___ O___

Physical Address Street_____ City_____ State _____ ZIP _____

Billing Address Street _____ City _____ State _____ ZIP _____

Primary phone (_____) _____

Cell Phone (_____) _____ May we text you for appointment reminders? Yes No

☐ Yes, you may leave a detailed message if I am not available. A detailed message will include personal medical information.

☐ No, do not leave any personal information when leaving messages.

E-Mail _____

Referred by: _____ Walk-in_____ Internet _____

Emergency Contact: _____ Phone# (_____) _____ Relationship _____

INSURANCE INFORMATION

____Office Copied Medical Cards ____ No Insurance (payment is due today) Is this a Work Comp visit? Yes____ No ____

Primary Insurance Name_____ ID_____ Group _____

Name of policy Holder _____ DOB_____

Secondary Insurance Name _____ ID _____ Group_____

Name of Policy Holder _____DOB _____

Co-pay amount $ _____ Copays are due at the time of service

Health Insurance Portability and Accountability Act or HIPAA
Acknowledgement of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Eye Surgery and Laser Center's Notice of Privacy Practices. Eye Surgery and Laser Center is permitted to revise its Notice of Privacy Practices at any time. A copy of our HIPPA policy is displayed in the office, as well as we will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing the other side of this form you are acknowledging that you are aware of the Eye Surgery and Laser Center's Notice of Privacy Practices.

Patient Communication

By law, without your authorization, Eye Surgery and Laser Center/Dr. Novak's Office cannot communicate your information with unauthorized persons. Please list below the names of people who we may communicate with regards to your appointments, medical/vision care or account information. You do not need to list Doctors or Primary Care Clinic Personnel.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do NOT wish to allow any of my information to be share with anyone including my spouse, or any other family members, friends, guardian or caregivers.

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. If this visit is for a cosmetic procedure, your payment will be due at the conclusion of each visit.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. I understand my insurance coverage is a relationship between my insurance company and myself and agree to accept financial responsibility for charges incurred, including co-pays, deductibles, or charges that are denied. In the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

I hereby authorize Eye Surgery and Laser Center to release all information necessary to secure payment.

By signing below, I am stating that I have read and I agree to the above information on both sides of this registration form, including financial agreement, HIPAA acknowledgement, demographics, and communications.

Print Name: _____ Signature: _____

Date: _____

Below will be signed the following years

By signing below, I am stating that I have re read and I still agree to the above information on both sides of this registration form, including financial agreement, HIPAA acknowledgement, demographics and communications.

Date: _____ Signature: _____

By signing below, I am stating that I have re read and I still agree to the above information on both sides of this registration form, including financial agreement, HIPAA acknowledgement, demographics and communications.

Date: _____ Signature: _____