HARMAN
EYE CENTER

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name		**Salutation**	Mr. Mrs. Miss Ms.
Date of Birth			
Sex		**SS #**	
Address			
City, State		**Zip code**	

Patient Communication					
Pref. Contact Method			Cell Home Work Email Text US Mail		
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Email**			

Information			
Marital Status		**Primary Care Provider**	
Occupation		**Employer**	

Account Responsible						
Responsible		**Date of Birth**				
Relationship		**SS #**				
Address						
Home Phone #		**Work Phone #**		**Extension**		
Email						

Primary Insurance			
Carrier Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

Secondary Insurance			
Carrier Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

Emergency Contact					
First		**Middle**		**Last**	
Relationship		**Home#**		**Cell#**	
Work#					

Release Of Medical Information - Status		
Name	**Relationship**	**Release Status**

I authorize and request examination by the physicians and staff of Harman Eye Centers including optometrists and ophthalmic technicians. I authorize the performance of whatever procedures the judgment of the above-named staff may deem necessary during treatment. I also authorize the administration of any anesthetics and analgesics, including eye drops, which the above staff deem advisable. I may request that any procedure not be performed. I authorize payment directly to Harman Eye Center of the insurance benefits otherwise payable to me for their services. I also authorize them to provide information to my insurance company directly pertaining to relevant claims. I understand that I may be charged and I agree to pay a fee for forms completion, medical records, collection agency or attorneys' fees pertaining to my account. By my signature below, I acknowledge that I have received the Harman Eye Center Notice of Privacy Practices.

Patient Signature: _____ DATE: _____

Witness Signature: _____ DATE: _____

Parent/Legal Representative: _____ DATE: _____

Insurance Fact Sheet for Non-Medicare Patients

Name: (please print)_____

Address: _____

Telephone #: _____
(home) (work) (cell)

1. Please circle any issues you are currently having:

Itchy Eyes	***Dry Eyes***	***Red Eyes***	***Eye Pain***	***Watery Eyes***
Difficulty reading small print		***Difficulty driving at night***	***Glasses don't fit or work as well***	
Double Vision		***Problems with glare***	***Can't see fine lines***	***Floaters***
Tired of wearing glasses		***Eye Strain***	***Change in Vision***	***Headaches***
Swollen Eyelids		***Droopy Eyelids***	***"Laugh Lines"***	***"Crow's Feet"***

2. Do you currently wear contact lenses? NO YES Are you having problems wearing? YES NO

3. Have you ever been diagnosed with any of the following? (Please circle all that apply)

Glaucoma Cataracts Diabetes Family history of Glaucoma High Blood Pressure

4. Are you interested in any of the following? LASIK BOTOX JUVEDERM LATISSE

Below is an explanation of what routine and medical eye exams include and payment options at Harman Eye Center:

A ROUTINE eye exam is to review the health of the eyes and your glasses or contact lens prescription if applicable. Only companies with very specific eye care plans pay for routine examinations. Refraction fees and contact lens fitting fees are in addition to the exam itself. Please be aware that you are responsible for advising us of your routine vision coverage prior to your eye exam. You may be able to use your routine benefits in our optical department. If you want this visit filed as routine, you must meet with a staff member to be sure that we participate with your insurance plan. If you have a ROUTINE DIAGNOSIS (no issues other than an updated prescription) and do not have a routine vision plan, we do ask that you pay for these services at the time of each visit. We accept cash, check, Visa, Discover and MasterCard. We will be happy to give you a receipt and a description of services rendered to enable you to file your insurance.

A MEDICAL exam is to assess any problems that you may be experiencing that may affect your vision (such as a change in your vision) or the comfort of your eyes (such as dry eyes or eye pain). If you are a patient who is being seen regularly in this office for a medical problem (e.g. glaucoma, cataracts, diabetes, etc.) or if you require specialized testing, your exam will be filed with your medical insurance. If your insurance requires a referral from your primary care provider you are responsible for obtaining the referral before you are seen.

Are you here today for a medical or a routine visit? (Please circle one) MEDICAL ROUTINE

If routine, what type of insurance do you have?_____

If we participate with your insurance we must collect your co-payment at each visit. This is a requirement of our agreement with your insurance company. Your co-payment was designed by your insurance company to assist in covering the cost of providing care to you. If you do not pay your co-pay, you are violating your insurance contract. If we violate our participation agreement by not collecting your co-pay and are not allowed to participate with your insurance company, the cost of services to you will rise. If you have questions regarding your payment obligations or your particular insurance, trained staff members are available to help you with your insurance questions.
It is important that you keep us up to date with changes in your insurance. If you are an established patient, you are responsible for letting us know if your insurance has changed since your last visit and providing us with your current insurance card so that we may make a copy for your records. THANK YOU!

_____

Patient Signature Date

Harman Eye Center
and its affiliates and/or subsidiaries

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Harman eye Center Privacy Practices.

_____
(Print Name)

_____
(Signature)

_____
(Date)

This acknowledgement page should be retained in the patient's record. If acknowledgement could not be obtained from patient, the reason(s) must be documented below.

_____
_____
_____
_____

RELEASE OF MEDICAL INFORMATION

By signing below, I authorize Harman Eye Center and affiliates and/or subsidiaries to disclose information regarding my eye care and treatment to the individuals listed below:

_____
Name Phone Number Relationship

_____
Name Phone Number Relationship

_____
Name Phone Number Relationship

_____
(Signature)

_____
(Date)