RASHID, RICE, FLYNN & REILLY
Eye Associates

PATIENT REGISTRATION FORM

Please Print

DATE:_____/_____/_____

PATIENT NAME: _____
(First) (Middle) (Last)

Date of Birth: _____/_____/_____ Street Address: _____

City, State, Zip: _____ Sex: M ___ F ____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: M ___ S ___ W ___ Social Security Number (if required by insurance): _____

Email: _____ Employer: _____

Referring Doctor: _____ Referring Doctor Phone: _____

Primary Care Physician (if different from Referring Doctor): _____

PCP Address: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Are you a resident of a Skilled Nursing Facility? _____ If yes, Name of Facility: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy #: _____

***Policyholder: _____ Date of birth of policyholder if different from insured _____

Secondary Insurance: _____ Policy #: _____

***Policyholder:_____Date of birth of policyholder if different from insured _____

Vision Plan Insurance: _____Policy #: _____

***Policyholder:_____Date of birth of policyholder if different from insured _____

ALL AMOUNTS DUE THAT ARE NOT COVERED BY INSURANCE WILL BE COLLECTED AT TIME OF APPOINTMENT

GUARANTOR OR IF PATIENT IS UNDER 18, LEGAL GUARDIAN TO COMPLETE ITEMS BELOW:

Name:_____
(First) (Middle) (Last)

Relationship to Patient: _____ Date of Birth:_____ Social Security #:_____

Address:_____

City, State, Zip: _____

Notice:

1. The Physician/Owners of this practice also own Mockingbird Optical Shop San Antonio, TX.
2. The Physician/Owners of this practice also own a partial interest in Specialty Surgery Center, San Antonio, TX.

Edward R. Rashid, M.D., F.A.C.S.
Robert A. Rice, M.D., F.A.C.S.
William J. Flynn, M.D., O.D.
Charles D. "Chaz" Reilly, M.D.
Gregory M. Brunin, M.D.

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Eye Associates

Mark G. Carolan, O.D.
George "Nick" Nicolas, Jr., O.D.
Melanie Gonzalez-Oliva, O.D.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES & PATIENT CONSENT FORM

Our "Notice of Privacy Practices and Patient Rights" provides information about how we may use and disclose protected health information about you. The notice includes your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have a right to review the Notice before signing this consent. The terms of the Notice may change. A current copy is available on our website or by contacting our office.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. However, it is our policy to limit use of your protected health information ("PHI") to providing your medical care, to bill for our services, to collect payment from you or your insurance company, for the general operation of the business, and for certain limited statutory purposes. **We do <u>not</u> sell, disclose, or use your information for marketing or fundraising purposes without your prior written consent.**

Federal privacy laws now limit our ability to communicate with your family and others regarding your medical care. If you wish to grant permission for us to disclose information to others, please indicate below. You have the right to revoke this consent at any time.

☐ ***Do not disclose my information to anyone but myself*** ☐ ***You may disclose information to the following:***

Name(s) _____ Relation: _____ Date: _____

By signing this form, you are acknowledging that you have been offered or provided a copy of our "Notice of Privacy Practices and Patient Rights" and consented to the disclosures above (if any).

_____	_____	_____
Patient's Printed Name	Signature of Patient or Legal Representative	Date

ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible for payment of any services rendered to me or my dependent. I understand the financial policies of the practice and have read or been offered a copy of the practice policies. I authorize the practice to release information necessary to process my insurance claims (to both primary and secondary insurance).

_____	_____
Signature of Patient or Legal Representative	Date