Eye Centers of Florida

SURGICARE CENTER

DATE: _____ **MR#** _____

PATIENT REGISTRATION

Last Name _____ First _____ MI ____ DOB _____ ☐ M ☐ F

Local Address _____ City _____ ST ___ Zip _____

E-mail address _____ SS# _____ Marital ☐S ☐M ☐D ☐W

Primary phone # _____ ☐Home ☐Cell Other Phone # _____

Preferred communication ☐ Eng ☐ Span ☐ Other _____ Year round resident? ☐ Y ☐ N

Northern Address _____ City _____ ST ___ Zip _____

The State of Florida requires that we gather the following information (please check the appropriate box):

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islands
- ☐ White
- ☐ Other Race
- ☐ Decline to answer

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Decline to answer

Emergency Contact (other than someone at the same address): Name: _____

Relationship: _____Primary phone # _____ ☐ Home ☐Cell

INSURANCE INFORMATION (We will scan the front/back of your insurance cards)

☐ If you are working, Employed by: _____

☐ Retired – If retired, is Medicare your primary insurance? ☐ Y ☐ N

RESPONSIBLE PARTY (If patient is responsible, check here ☐)

Last name _____ First _____ SS# _____ DOB: _____

Relationship to patient: _____ Primary phone # _____ ☐ Home ☐Cell

PRIMARY Insurance: _____

SECONDARY Insurance: _____

VISION Insurance: _____

REFERRAL INFORMATION (Whom may we thank for referring you to our office? _____

- ☐ My optometrist _____
- ☐ My family physician _____
- ☐ My insurance plan
- ☐ Eye Centers Employee _____
- ☐ Family/patient/friend
- ☐ Discount/Promotion
- ☐ Seminar
- ☐ Health Fair
- ☐ ECOF Website
- ☐ Facebook
- ☐ Internet Ad
- ☐ Twitter
- ☐ Billboard
- ☐ Hero Care Rewards
- ☐ Seminole Tribe
- ☐ Independent
- ☐ Ft. Myers News Press
- ☐ Naples Daily News
- ☐ Florida Weekly
- ☐ Senior Blue Book
- ☐ Lifestyles Over 50
- ☐ Radio
- ☐ Television
- ☐ Other _____

ADVANCED DIRECTIVE: If you wish for us to have a copy of your advance directive, please provide it to us. Should it be necessary for you to be transferred to the hospital, this advance directive would accompany you to the hospital.

I understand that I am responsible if my insurance requires a referral and obtaining such referral from my primary care physician. I am financially responsible for all co-pays, deductibles and charges not covered by insurance, as well as any other purchased miscellaneous items (e.g.: glasses, contacts, aesthetic items, medications). The patient and insurance information listed on this document is current and accurate for today's services.

_____ _____

Patient/Responsible Party Signature Date

Notice of Privacy Practices and Authorization for Access to Protected Health Information/Records

Insert Patient Label

DATE: _____ MR#: _____

Last Name _____ First _____ MI ____ DOB _____

I hereby authorize Eye Centers of Florida and/or Surgicare Center, Inc. to disclose my Protected Health Information (PHI) to the noted individuals:	☐ Family Member ☐ Personal Representative	**Name:**
	☐ Family Member ☐ Personal Representative	**Name:**
	☐ Family Member ☐ Personal Representative	**Name:**

I authorize the release of any medical information necessary for my treatment and to process claims as well as authorization of payment directly to Eye Centers of Florida and/or Surgicare Center, Inc.

Please note: This authorization shall become effective immediately.

The undersigned represents that he/she has read and understands the information contained here, and that they agree to the conditions of this Authorization. **I understand that this authorization is voluntary and that I may refuse to sign this authorization**. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

I acknowledge that I am aware of the Notice of Privacy Practices (HIPAA) for this office/surgery center.

_____ _____

Patient/Responsible Party Signature Date

CONFIDENTIALITY NOTICE
CONFIDENTIAL HEALTH INFORMATION ATTACHED

Protected Health Information is personal and sensitive information related to an individual's health care. It is being transmitted to you by facsimile after appropriate authorization from the patient or under circumstances that do not require patient authorization. You as the recipient are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure of this information without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. If you have received this message in error, please notify the sender to arrange for return or destruction of these documents.