WELCOME TO OPHTHALMIC PLASTIC CONSULTANTS (OPC)

In order to provide the best care to our patients, we ask that this **NEW PATIENT REGISTRATION** form be completed in its **ENTIRETY**. Any personal information provided will be kept in the strictest confidence. HIPAA regulations require written consent from our patients prior to sending information to medical entities, (i.e. insurance companies, referring providers, etc.) and insurance companies require specific information in order to process your medical claim(s). If you are unable to provide all the information, we will kindly accept full payment and provide you with the necessary paperwork to submit your claim directly to your insurance company for direct reimbursement. Whomever presents the patient for medical care is the responsible party.

Patient Name (First MI Last):______________________ Date of Birth:__________ Sex:________
(As it appears in insurance carrier records. Your chart will be filed, and appointments will be entered under this name.)
Patient Social Security Number:______________________ If under 18, Parent/Guardian Name:______________________

Race:______________ Marital Status:______________ Email:______________________

Street:______________________ City:______________ State:________ ZIP:__________

Home #:______________ Work #:______________ Cell #:______________

Emergency Contact Name (*& Relationship*) with Phone #:______________________

Whom should we thank for your referral today? Please check any that apply:

☐ **Primary MD** ***(REQUIRED** for Medicare/HMO)*______________ ☐ **Referring MD** ***(REQUIRED** for coordination of care)*______________
☐ **Internet/Magazine/Yellow Pages/Advertisement** *Please specify*______________________ ☐ **Self-Referred**

Primary Insurance Information

PLEASE NOTE: Please have your insurance card and picture ID ready for photocopying/scanning. Also, OPC ONLY bills secondary insurances when Medicare is Primary.

Insurance Name:______________________ Policy Holder's Name:______________________

Policy Holder's DOB:______________ Policy Holder's SSN:______________ Patient's Relationship to Policy Holder:__________

Assignment of Benefits

If Medicare or my commercial insurance carrier should deny any and all charges, then I agree to be personally and fully responsible for any and all balances. **I understand that I am financially responsible for any balances not covered by my insurance carrier.**

Name:______________________ Phone #:______________ Relationship to Patient:______________
(If different from above.)
Street:______________________ City:______________ State:________ ZIP:__________
Medicare and private insurance carriers will only pay for services determined to be reasonable and customary under Section 1862(a)(1) of the Medicare Law. Private and commercial insurances can deny coverage for the following reasons:

a. OPC or Dr. Soheila Rostami or Dr. Lindsey is not a specialist in the particular insurance plan.
b. Patient is not listed as a covered member or dependent.
c. Patient policy has terminated at time of service and/or patient did not present new insurance information.
d. Patient did not present a valid referral at time of service. *(It is patient's responsibility to verify if they need a referral per their insurance plan.)*
e. Insurance will usually not cover charges for **refraction**. *(This fee may be due at time of service.)*

I certify that the information given for payment is correct. I authorize direct payment of surgical/medical benefits to OPC and Dr. Soheila Rostami/Dr. William Lindsey for services rendered by her or under her supervision. I request payment of authorized benefits be made on my behalf.
Failing to sign this section will indicate you will pay for your visit today and request direct reimbursement from your health plan…this is a refusal of assignment of benefits to the provider. By signing, you are confirming that you are the financially responsible party and that you have read & accepted our Financial Standards & Practices (posted in lobby).

Patient/Parent/Guardian Signature:______________________ **Date:**______________
(A photocopy of these signed & accepted assignments shall be as valid as original.)

Consent to Use and Disclosure of Protected Health Information (HIPPA)

Your protected health information will be used by OPC or disclosed to others for the sole purpose of medical treatment, obtaining payment, or supporting day-to-day health care operations of the practice. You should review the NOTICE OF PRIVACY PRACTICES (available by request) for a more complete description of how protected health information may be used or disclosed. You may review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information in writing. If OPC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which the revocation of consent is received will not be affected.

OPC reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and give permission for OPC to use and disclose my health information in accordance with it.

Printed Name of Patient/Patient Representative:______________________

Patient/Parent/Guardian Signature:______________________ **Date:**______________

If you would like a copy of this completed Patient Registration for your records, please ask the Receptionist for a copy.

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