Campus Eye Group New Patient Registration Form

New Pt Packet 02.27.25

Patient Information

Patient Last Name	First Name		Middle Name	Maiden Name	
Address (Street or Box)			City	State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number	E-Mail	
Social Security Number	Date of Birth	Assigned Sex at Birth ☐Male ☐ Female	Pronouns ☐She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐Other: Please specify: _____		
Gender Identity (Check One) ☐ Identify as Male ☐ Identify as Female ☐ Gender Nonconforming/Non-binary ☐ Other (Please specify)_____ ☐ Choose not to disclose			Sexual Orientation (Check One) ☐ Lesbian/Gay/Homosexual ☐Straight/Heterosexual ☐ Bisexual ☐Something else, please describe _____ ☐ Don't Know ☐ Choose not to disclose		
Marital Status (Check One) ☐Single ☐Married ☐Domestic Partner ☐Separated ☐Divorced ☐Widowed ☐Unknown			Race (Check One) ☐ American Indian or Alaska Native ☐Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐Other _____		
Ethnicity (Check One) ☐ Not Hispanic or Latino ☐ Hispanic or Latino			Employer Name	Employer Address	
Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center? ☐ Yes ☐ No			If Yes, Name of Facility	City: Phone Number:	
Primary Care Physician Name			Phone Number		
Emergency Contact & Relationship	Phone Number		Referring Physician Name	Phone Number	

Responsible Party

Complete this section ONLY if Patient is a minor or has a Legal Guardian

Responsible Party Last Name	First Name	Middle Name	E-Mail:	
Address (Street or PO Box)		City	State	Zip Code
Home Phone Number		Cell Phone Number	Work Phone Number	
Relationship to Patient ☐Self ☐Other (specify)		Date of Birth	Social Security Number	

Insurance and Subscriber Information

PRIMARY Insurance Company		Effective Date	**SECONDARY** Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)			Claims Mailing Address (Street or PO Box)		
City	State	Zip Code	City	State	Zip Code
Policy ID Number	Group ID Number		Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth		Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient		Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number		Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)			Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code	City	State	Zip Code

Pharmacy

Preferred Pharmacy Name	Pharmacy Address	Pharmacy Phone Number
Mail-Order Pharmacy Name	Pharmacy Address	Pharmacy Phone Number

Vision Insurance (if applicable)

Vision Insurance and Subscriber Information

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Treat and Financial Responsibility

Consent to Treat

I hereby authorize employees and agents of Total Eye Care Centers, PC an Affiliate of Campus Eye Group including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

_____

Patient Name (Please PRINT)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize Total Eye Care Centers, PC an Affiliate of Campus Eye Group to apply for benefits on my behalf and for payment of medical benefits directly to TECC for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to Total Eye Care Centers. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Total Eye Care Centers.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

_____

Patient Name (Please PRINT)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Patient Preferences Regarding Communication of PHI
(Protected Health Information)

Preferred Method of Communication

☐ **Yes**, I want Total Eye Care Centers, PC an Affiliate of Campus Eye Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my **medical conditions and/or appointment information** is indicated below:

☐ Home Phone ☐ Cell Phone ☐ Email ☐ Mailed Letter ☐ Guardian

If the above method of communication is by **phone**, please do one of the following (**please check ONE**):

☐ Leave a message with detailed information.
☐ Leave a message with a call-back number only.

If the above method of communication is by **email**, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that Total Eye Care Centers, PC an Affiliate of Campus Eye Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate check boxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient	Contact Phone Number	End Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

Contact Name	Relationship to Patient	Contact Phone Number	End Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

Patient Name: _____ **Date:** ____/____/_____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Total Eye Care Centers, PC an Affiliate of Campus Eye Group, is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On ____/____/_____ I, _____, received a copy of this office's Notice of Privacy Practices.
(Today's Date) (Patient's Name)

_____
Please Print Name

_____
Signature

_____
Date

*Campus Eye Group Notice of Privacy Practices can also be found on our website: https://www.campuseyegroup.com

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

This Acknowledgement Form will become part of your permanent medical record.