RASHID, RICE, FLYNN & REILLY
Eye Associates

PATIENT REGISTRATION FORM

Please Print

DATE:_____/_____/_____

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

Street Address: _____

City, State, Zip: _____ Drivers License#_____

Social Security #: _____ Date of Birth: ____/____/_____ Age:_____

Sex: M ___ F___ Home Phone:_____ Work Phone: _____

Marital Status: M ____ S ____ W ____ Email: _____ Cell Phone: _____

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

Pharmacy for Prescriptions _____ Phone:_____

Emergency Contact Name: _____ Phone:_____

Employer Name: _____

Employer Address: _____

Spouse Name: _____Spouse Employer: _____

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 _____

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

NAME OF YOUR PRIMARY CARE PHYSICIAN: _____

List any known allergies: _____

Are you a resident of a Skilled Nursing Facility? _____. If yes - Name of Facility _____

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

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

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

Address:_____

Employer Name: _____ Employer Phone #:_____

Employer Address:_____

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. Reilly, M.D.
Mark G. Carolan, O.D.

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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 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.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing. However, such revocation shall not affect any disclosures we have already made in reliance of your prior consent.

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

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: _____

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