PATIENT REGISTRATION FORM

Patient LEGAL name _____ SEX: M / F
First Middle Last

BIRTHDATE _____ AGE _____ SSN _____

MARITAL STATUS: Single / Married / Widow / Divorced / Other

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME (_____)_____ WORK (_____)_____ CELL (_____)_____

E-MAIL _____@_____

REFERRED BY _____ PRIMARY CARE PHYSICIAN_____

PERSON TO NOTIFY IN CASE OF EMERGENCY_____

RELATIONSHIP TO PATIENT_____ PHONE (_____)_____

INSURANCE INFORMATION

INSURANCE ASSIGNMENT AND RELEASE INCLUDING MEDICAL ASSISTANCE

I understand that I am personally liable for any charges not covered by my insurance company, including medical assistance. I also understand that this account and the charges incurred are my responsibility and if my medical coverage is pending, my account will be treated as a self pay account until I produce an active insurance. I hereby authorize **Lance K. Bergstrom, MD, Tracie Teig Malsom, OD and Matthew Stein, OD**; the doctor's billing company or staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions either via paper claim or electronically.

_____

Responsible Party Relationship to Patient (if not patient) Date

MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits be made on my behalf for any services furnished to **Lance K. Bergstrom, MD, Tracie Teig Malsom, OD, and Matthew Stein, OD.** I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have a secondary insurance company as I have indicated, my signature authorizes release of the information to the insurer or agency shown whether submitted by paper claim or by electronic means. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and I understand that I am responsible for any deductible and co-payment amounts. I also understand that some services may not be covered by the Medicare program and that I am responsible for payment of those services.

_____

Medicare recipient's signature Date

Bergstrom Eye and Laser Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below: Our clinic will not share your personal information per HIPAA guidelines, unless other parties are listed below.

_____
Please Print Name

_____ _____
Signature Date

☐ I am the only person authorized to obtain medical/financial records in any way.

OR

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION (This includes your spouse, children, care takers, etc.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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)