NEVADA RETINA ASSOCIATES

PATIENT REGISTRATION

Patient Information:

Last Name	First Name	MI	Suffix

Date of Birth	Age	Sex M F	Social Security Number	Marital Status (Circle) S M D W

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Employer	Occupation

Responsible Party (Last, First)	Relationship

Mailing Address	Home Phone	Work/Cell Phone

Medical Insurance Information:

Is this a work-related accident? YES NO	If Yes, name of Worker's Comp/Claim #:
Do you have Medicaid? YES NO	If so, for what state? / Policy #:
Do you live in a Skilled Nursing Home? YES NO	If so, what facility / Contact Person:

Insurance Information (Primary):

Carrier	Group/Policy Number	Effective Date

Name of Policy Holder (Last, First)	Policy Holder SSN	DOB

Patient Relationship to Policy Holder (circle one)	SELF SPOUSE DEPENDENT OTHER: _____

Insurance Information (Secondary):

Carrier	Group/Policy Number	Effective Date

Name of Policy Holder (Last, First)	Policy Holder SSN	DOB

Patient Relationship to Policy Holder (circle one)	SELF SPOUSE DEPENDENT OTHER: _____

Emergency Contact (s):

Name (Last, First)	Relationship	Phone
Name (Last, First)	Relationship	Phone

Physician Information:

Referring Physician (Full Name & Phone Number)	Optometrist (Full Name & Phone Number)
Ophthalmologist (Full Name & Phone Number)	Primary Care Provider (Full Name & Phone Number)

Consent to Use and Disclose Protected Health Information:

- I hereby give consent for Nevada Retina Associates to use and disclose protected health information (PHI) to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices has been furnished to me by Nevada Retina Associates and describes such uses and disclosures in more depth [in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)]. I have the right to review the Notice of Privacy Practices prior to signing this consent.
- I understand that Nevada Retina Associates reserves the right to change its privacy practices as described in the Notice. In the event of a revision in Nevada Retina Associates' privacy practices, the Notice will be available to me upon written request.
- I understand that this authorization is voluntary and may be revoked at any time by notifying Nevada Retina Associates. Any revocation will become effective on the date it has been received by Nevada Retina Associates and will apply to uses and disclosures after the date of receipt.
- With this consent, Nevada Retina Associates may call my home or other alternative and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I authorize the release of protected health information by Nevada Retina Associates to my referring provider and to (please initial next to any applicable disclosures):

_____ **The physicians that I have listed above** (in the 'Physician Information' section of this form)

_____ **Myself** (I understand that there is a fee of 60¢ per page and $1.00 per IVFA/OCT photo should I wish to request records for myself. I also understand that more information regarding copying fees under Nevada Revised Statute (NRS) 629.061is available upon request.)

_____ **A 'Notice of Privacy Practices' has been made available to me** (for my review as well as a copy for my personal records, should I require one)

I designate the following representative(s) to receive communication from Nevada Retina Associates regarding my PHI. Please note: If you do not designate any representatives, Nevada Retina Associates will not be able to release any of your health information.

Name	Relationship	Phone #
Name	Relationship	Phone #

Power of Attorney (if applicable):

Name (Last, First)	Signature	Copy of Proof On File (Initial) _____

Patient Signature	Date