NEW PATIENT REGISTRATION FORM

Last Name: ______________________________First Name: __________________ MI: __________ **Date:** ________________

DOB:_______________________________ Age: ___________________ Gender: Female / Male

Race: ________________________ Ethnicity_________________________ Language______________________________

Marital Status (please circle): Married / Single / Divorced/Widowed

Address: ____City: __________________State:______ Zip Code: _____________

Home Phone # ____________________________________ Cell Phone #______________________________________

What is your preferred contact method (circle one) Patient portal Phone Mail

Email Address: ____

Emergency contact ____ Phone #: __________________________

Guardian ____ Phone #: __________________________

Is today's visit due to an Injury? Yes or No Date of Injury _____________________________________

Referring Doctor ____ Phone # ________________________________

Address ____City ____________________ State _______Zip Code:__________

Family Doctor ____ Phone # ________________________________

Address ____ City ____________________ State _______Zip Code: _________

3033 Excelsior Blvd, Suite 205, Minneapolis, MN 55416
Tel: 612-470-9871, Fax: 612-470-9881
Website: eyecarempls.com, E-mail: clinic@eyecarempls.com

NEW PATIENT REGISTRATION FORM

Last Name: ___________________________First Name: ________________ MI: _________ **Date:** ______________

Constitutional: None / Weight loss/Weight gain/Fatigue/Fever/Other: _______________________________

Ocular: None / Glaucoma/Macular degeneration/Other: ____________________________________

Ear/Nose/Throat: None / Hearing loss/ Upper respiratory infection/Other: _____________________________

Cardiovascular: None / Hypertension/Stroke/Heart Disease/Other: __________________________________

Respiratory: None / Asthma/Bronchitis/Emphysema/COPD/Other: ________________________________

Gastrointestinal: None / Crohn's / Colitis /Other: ____

Musculoskeletal: None / Arthritis/Joint pain/Other: ____

Psychiatric: None / Depression/Anxiety/Other: ____

Neurological: None / MS/Epilepsy/Cerebral Palsy/Other: ____

Endocrine: None / Diabetes/Thyroid problems/Other: ____

Immunologic: None / Rheumatoid Arthritis/Lupus/Other: ____

Hematological: None / Anemia/ Leukemia/Other: ____

Dermatologic: None / Eczema/ Rosacea / Psoriasis/Other: ____

Surgeries: None / Other: ____

Allergies: None / Other: ____

Medications: ____

Eye drops: ____

Alcohol Use: Yes / No / Amount: ________________ **Tobacco Use:** Yes / No / Amount:_____________________

Family History: None / Cancer/Diabetes/Hypertension/Glaucoma/Other: ________________________________

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NEW PATIENT REGISTRATION FORM

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of any information relating to all claims without obtaining my signature on each and every claim for benefits submitted on behalf of myself and/ or dependents. I hereby authorize payment directly to Eye Care Mpls PLLC for all medical and major benefits present and future for myself and/or dependents. I understand that I am financially responsible for all Co-payments, deductibles, or amounts not covered by my insurance carrier.

Signature of Patient/ Guardian:____

Patient Name:____ Date ______________________

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NEW PATIENT REGISTRATION FORM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting Records From:____

____

Please release the following medical records of the patient above to:
Stella Hennen, MD, MSPH
Eyecare MPLS PLLC
3033 Excelsior Blvd
Suite 205
Minneapolis, MN 55416

Fax records to this number: 612-470-9881

	History & Physical Exam		Consultation Reports
	Operative Note		Pathology, Lab & X-Ray
	Progress Notes		Other

Patient Last Name: ______________________ First Name: ______________ MI: ______

DOB: __________________ Other Names Used: ______________________________

Patient's address:____

____

Patient's Phone Number: ____

I hereby authorize the release of any information from my exam including diagnostic tests and photographs. This does not authorize re-release of the information to anyone. A photocopy will be treated as the original.

Signature of Patient/ Guardian: ____

Patient Name: ______________________________________Date: ______________

NEW PATIENT REGISTRATION FORM

ACKNOWLEDGMENT OF RECEIPT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY PRACTICES NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Eyecare MPLS's Notice of Privacy Practices. Eyecare MPLS is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. By signing below, you are acknowledging that you have received a copy of Eyecare MPLS Notice of Privacy Practices.

Signature of Patient/Guardian:____

Patient/ Guardian Name:_______________________________________Date:_______________

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NEW PATIENT REGISTRATION FORM

Insurance

You are ultimately responsible for the cost of your eye care at Eye Care Mpls. Please bring your insurance card(s) with you to every office visit. Accurate, up-to –date, and complete insurance information, and an understanding of your insurance carriers policies regarding co- payments and deductibles will minimize the potential for financial surprises and misunderstandings.

The Eye Care Mpls Business Office phone number is 612-470-9871. **If you are a new patients to Eye Care Mpls**, please call the Eye Care Mpls business office prior to your first visit to our practice to provide your complete insurance information. **If you are an existing patient whose insurance has changed**, please call the Eye Care Mpls business office promptly to inform us of your new insurance information. If you have questions about our participation in your insurance program or health plan, you may call your insurance plan or our business office. **We are participating physician in Medicare.**

If you do not have insurance we require payment of initial estimated charges at the time of service. See Self-Pay Policy below.

Picture Identification

Due to widespread insurance fraud and identity theft, picture identification is required when you register in our office.

Insurance Required Co-pays

Insurance required "Co-pays" are due at the time of service. If you are unable to make this payment, we will reschedule your appointment to a time when you are able to pay your co-pay. You may also contact our Business Office ***prior*** to your appointment at 612-470-9871 to make financial arrangements.

Payment options

Our office accepts cash, checks and credit card payments.

Submission of claims

As a courtesy, we will bill your insurance for all services. If there is a remaining balance due after your insurance carrier pays, Eye Care Mpls will send you an invoice. You have 30 days to make payment on the invoice. Any account not paid within 30 days of billing will be considered delinquent. Payment arrangements can be made for special circumstances by contacting the Business Office at 612-470-9871. We urge you to keep your account current to avoid any misunderstandings with our office. Account balances past due over 30 days may be sent to an outside agency for collections. If your account is sent to collectors, the account is out of our hands. If you need to make special payment arrangements, it is your responsibility to contact our Business Office before your account is turned over to an outside agency.

NEW PATIENT REGISTRATION FORM

Self-Pay Policy
All cash patients and patients without valid insurance information are considered Self-Pay Patients and must pay for services at the time the service is provided. Complete eye exam for new patient costs $300.00. Prescription for glasses costs $50.00. 50% of the whole amount $175.00 must be payed prior to the eye exam. The rest of the balance can be paid in monthly installments of $43.75 over 4 months.
All Self-Pay Patients must contact our business Office at 612-470-9871 prior to your appointment. If you and the physician determine that you need additional appointments, treatment or testing, you should contact the Business Office to make additional payment arrangements prior to scheduling.

Other charges you may Incur
If we are asked to complete additional forms or reports for you there may be additional charges. These fees will ***not*** be billed to your insurance company. Eye Care Mpls may charge fees for the following:

-Disability Forms $15
-FMLA forms $15
-Driver's form $15
-Copies of medical records $15
-Returned checks $30

Check Processing
When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. For inquiries, please call
612-470-9871.

I have read the Eye Care Mpls, PLLC financial policy and have been given an opportunity to ask questions on any points that I did not understand. I agree to abide by the policy.

Signature of Patient/Guardian:____

Patient/Guardian Name: ____Date:________________

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