REGISTRATION FORM

(Please Print)

Today's date:	**Primary Care Physician:**
Eye Physician:	**Pharmacy:**

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Mailing Address:	City:	State:	ZIP Code:

Social Security Number:	Home Phone Number: ( )	Cell Phone Number: ( )	Preferred method of contact: ❑ Home ❑ Cell ❑ Work

E-mail address:	Employer/Occupation:	Work phone number: ( )

* By providing my email address to NWARA I understand that I will be registered for access to my online patient portal and to my clinical information as well as secure messaging with my provider

Referred to clinic by (please check one box): ❑ Dr.	❑ Insurance Plan	❑ Hospital	❑ Family ❑ Friend
	❑ Close to home/work	❑ Yellow Pages	❑ Other (please list)

Race:	Ethnicity:	Primary Language:

Name of local friend or relative in case of emergency:	Relationship:	Phone #

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Company Name:				
Insurance Subscriber's Name:				
Subscriber's Birth date: / /		Subscriber's SSN:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

Any deductible amount, co-insurance and/or any copay is due at check in.
If you are unable to pay the amount due at the time of check-in,
you may be asked to reschedule your appointment.
Delinquent bills will be turned to Collection Agency if not paid in full within 90 days. Up to 30% collection fee may be added if turned to collection agency.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I acknowledge I understand the billing practices of NWARA. I also authorize Northwest Arkansas Retina Associates, P.A. or insurance company to release any information required to process my claims. A photocopy of the assignment is to be considered as valid as an original.

X

Patient/Guardian signature *Date*

HEALTH INFORMATION AND INSURANCE PRACTICES

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices of NWA Retina Associates, PA. I understand that NWA Retina is committed to treating and using my health information responsibly. I understand how my information may be disclosed. I understand my health records are the physical and legal property of NWA Retina Associates, PA, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs may be incurred for copies of my records. I may be asked to make an appointment with the doctor of office manager to inspect, access or amend my records. NWA Retina Associates, PA will require my signed authorization to release my health information to outside sources with the exception of disclosures for purposes of treatment, payment, and health care operations. These may include: access my health information by NWA Retina Associates, PA staff and physicians, billing to myself or third party payer; in addition, business associates of NWA Retina Associates, PA may from time to time, have access to my health information, but I am assured the proper Business Associates Agreements are in place.
Upon the Physician's best judgment , NWA Retina Associates, PA may disclose to a family member, relative, or close personal friend or any other person I identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health; legal authorities; and / or law enforcement purposes.
NWA Retina may call me with appointment reminders, cancellations and may leave messages at my home, cell phone or place of employment.

I have read and understand the above practices of NWA Retina Associates, PA.

X

Patient / Guardian Signature Date

**Please list any friends or family members that may accompany you in the exam room or that you give permission to contact our office and speak with our staff on your behalf. If a person calls or comes in to the office to speak with us on your behalf and they are not listed, we will not be able to give them any of your protected health information.

Family / Friend Relationship Phone

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