BERKELEY OPHTHALMOLOGY MEDICAL GROUP, INC.

PATIENT REGISTRATION

Form F-6
Rev. 01/19

Please Print Clearly

☐ MR.	**SEX**	**SEXUAL ORIENTATION**	**GENDER IDENTITY**		**MARITAL STATUS**
☐ MS.	☐ Male	☐ Straight or heterosexual	☐ Male	☐ Transgender Male	☐ Single
☐ DR.	☐ Female	☐ Lesbian, gay or homosexual	☐ Female	☐ Transgender Female	☐ Married
☐ MRS.		☐ Bisexual	☐ Genderqueer	☐ Declined to Specify	☐ Domestic Partner
☐ MISS		☐ OTHER:			☐ Divorced
☐ OTHER:		☐ Declined to Specify	☐ OTHER		☐ Widowed

LAST FIRST MI	Birth Date:
Also Known As:	Home Ph:
ADDRESS: STREET CITY STATE ZIP CODE	Work Ph:
	Cell Ph:
	SSN:

How did you hear about us? ☐ Friend ☐ Doctor ☐ Insurance ☐ Website ☐ Other _____	E-Mail Address:	DO YOU UNDERSTAND ENGLISH? ☐ Y ☐ N
	Referring Dr.:	Ref. Ph:
	Family Physician:	F.P. Ph:
	Optometrist:	Opto. Ph:
	Pharmacy:	Pharm. Ph:

Emergency Contact:	Relationship to Patient	Home Ph: Cell Ph:

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT: _____

Last First Mi	Home Ph:
Address: Street City State Zip Code	Work Phone
E-Mail Address:	Cell Ph:

ASSIGNMENT OF BENEFITS (Required to bill your Insurance)

PLEASE COMPLETE & SIGN

I hereby authorize direct payment of insurance benefits available for professional and/or surgical benefits to which I am entitled to Berkeley Ophthalmology Medical Group, Inc. I authorize Berkeley Ophthalmology Medical Group, Inc. to release any information acquired in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by insurance.

PATIENT/ GUARDIAN SIGNATURE _____ **DATE** _____

PATIENT/ GUARDIAN NAME (PLEASE PRINT) _____

AFTER HOURS EMERGENCIES

Call our office (510) 548-6630 and speak with our answering service. If no ophthalmologist is available, Alta Bates emergency room has an ophthalmologist on call at all times.

Continued on the Back

EMPLOYMENT INFORMATION

Current/Former Profession: _____

☐ Full-Time	☐ Part-Time	☐ Retired	☐ Not Employed
Employer:		Employer Ph:	
Is the Patient's Condition Is Related To: ☐ Employment ☐ Auto Accident ☐ Other:			

INSURANCE INFORMATION

☐ **NO INSURANCE**

(1st) PRIMARY INSURANCE	ID NUMBER:
SUBSCRIBER'S NAME:	PLAN NUMBER:
SUBSCRIBER'S BIRTH DATE:	SUBSCRIBER'S SSN:
SUBSCRIBER'S RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
(2nd) SECONDARY INSURANCE	ID NUMBER:
SUBSCRIBER'S NAME:	PLAN NUMBER:
SUBSCRIBER'S BIRTH DATE:	SUBSCRIBER'S SSN:
SUBSCRIBER'S RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
(3rd) TERTIARY INSURANCE	ID NUMBER:
SUBSCRIBER'S NAME:	PLAN NUMBER:
SUBSCRIBER'S BIRTH DATE:	SUBSCRIBER'S SSN:
SUBSCRIBER'S RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	

A BRIEF DESCRIPTION OF NOTICE OF PRIVACY PRACTICES / HIPAA (Health Insurance Portability & Accountability Act)

For a more extensive version of our Notice of Privacy Practices/HIPAA. Please ask our staff or check out the resources page on our website: https://www.bomg.org

HIPAA gives you the ability to do any of the following:

- View the information listed in your health records
- Request corrections to information on said records
- Decide who can access and share your health information (and more importantly, who can't)
- Require providers and other healthcare facilities to request permission to share your information for marketing and other non-treatment purposes

Is All of My Information Protected?

- Any information a doctor puts in your medical record
- Information stored within the computer system of your health insurer
- Billing information from your healthcare provider
- Conversations your doctor has with nurses or other physicians regarding your treatment or care

If at any time you feel that your privacy rights have been violated, HIPAA regulations allow you to file a complaint with Health and Human Services, or file a complaint directly against your insurer or provider. Failure to comply with HIPAA regulations can result in many negative consequences for a healthcare provider. These include both civil and criminal penalties.

All healthcare workers must undergo some kind of training or education on HIPAA compliance. Health insurance companies must follow HIPAA regulations. Any Healthcare provider who conducts business electronically must comply with all recent regulations.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

PATIENT/ GUARDIAN SIGNATURE _____ **DATE** _____

PATIENT/ GUARDIAN NAME (PLEASE PRINT) _____

If not signed by the patient, please indicate: Relationship:

Complete the following only if the Patient refuses to sign the Acknowledgment.

Reasons for refusal: