

JOHN L. BONNER EYE CLINIC, LTD.  
REGISTRATION

Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Marital Status: (circle) Single Married Widow Divorced

Referring Doctor \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

Patient's Parent/Guardian (if a minor) \_\_\_\_\_

Have you been seen here in the past under a different name? If so, what was previous name: \_\_\_\_\_

Patient's Employer Name & Address: \_\_\_\_\_

Responsible Party/Billing Information

Primary Insurance Company Name: \_\_\_\_\_ ID/Policy # \_\_\_\_\_

Acct/Group # \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Patient's relationship to Policy Holder \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Holder's SSN \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_ ID/Policy# \_\_\_\_\_

Acct/Group# \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Patient's relationship to Policy Holder \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Holder's SSN \_\_\_\_\_

Send bill to: Patient \_\_\_ Employer \_\_\_ Other/Relationship \_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

**(PLEASE COMPLETE BACK SIDE)**

**JOHN L. BONNER EYE CLINIC, LTD.**

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**LIFETIME SIGNATURE AUTHORIZATION**

This constitutes my authorization for John L. Bonner Eye Clinic, Ltd. and its billing agent to file claims on my behalf. This authorization is to be a lifetime authorization Effective: DATE \_\_\_\_\_.

**ASSIGNMENT OF INSURANCE AND PAYMENT AGREEMENT**

I Hereby authorize payment of all Insurance Benefits, including Major Medical, Title XVII Medicare, Title XIX Medicaid, or any other private insurance company to the holder of this authorization. I also acknowledge that I am responsible for non-covered charges, co-insurances and deductibles.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND WAIVER**

For medical services provided to me by John L. Bonner Eye Clinic, Ltd., I authorize any holder of medical information documentation about me to release to the Social Security Administration and Center for Medicare/Medicaid Services or its intermediaries or carriers, or any private insurance company and their agents and carriers, any information needed to determine these benefits or benefits payable for this or a related medical service provided to me by John L. Bonner Eye Clinic, Ltd. Now or in the future. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment or myself, if no assignment is taken.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT IF A MINOR OR UNABLE TO SIGN:**  
\_\_\_\_\_

# John L. Bonner Eye Clinic, Ltd. \_\_\_\_\_

Diseases, LASER, Surgery of the eye and Refractive eye surgery

Timothy C. Bonner, M.D.  
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John L. Bonner, M.D.  
1962 - 1990

## PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restriction. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Print Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

I give BEC my permission to discuss my protected health information with:

My spouse    YES    NO

Others        YES    NO    If yes, please list names \_\_\_\_\_