

HATTORI VISION STUDENT REGISTRATION

Mr / Miss _____

Today's Date _____

Nickname _____

Birth Date _____

Home Address:

Mailing Address (if different):

Home Phone: _____

School/Grade: _____

E-Mail Address: _____

Cell Phone: _____

Mother's Name: _____

Father's Name: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Employer: _____

Employer: _____

Payment is due at the completion of the examination and/or on delivery of material.

Bill Payer:

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Insurance: (Please give the front desk any forms or insurance cards)

Vision: _____ Medical: _____

Social Security #: _____

I authorize payment of benefits to Hattori Vision. I also understand that any recommended, additional procedures will be billed to my medical insurance, and that I will be responsible for any fees not covered by my insurance within 90 days.

(Signature of Parent or Guardian)

(Date)

Hobbies often have special visual requirements. What hobbies / sports do you enjoy?

Are you interested in discussing contact lenses? Yes No Already wear

Do you work on a computer more than 3 hours a day? Yes No

Are you interested in discussing refractive therapy / surgery? Yes No

If you are a new patient, whom may we thank for referring you to us? _____

Receipt of Notice of Privacy Policies & Consent Form

Hattori Vision Optometry
757 Pacific Street Suite C-1, Monterey, California, 93940
831-372-8181
831-372-7433

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Hattori Vision Optometry.

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient Print Name

Source of Authority: _____