WESTERN CAROLINA EYE ASSOCIATES, P.A.
REGISTRATION FORM

(Please Print)

Today's date:				Primary Care Physician:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div. / Sep / Wid	
Billing address:				Primary Address? ❑ Yes ❑ No	How did you hear about us?	
City:	State:	Zip Code:	Sex:	Date of Birth:	Race:	Ethnicity: ❑Hispanic ❑Not Hispanic
Preferred Pronoun:	Home #: ( )	Cell #: ( )			Email:	
How would you prefer that we contact you? CALL☐ TEXT☐ EMAIL☐ Other family members seen here:						

INSURANCE INFORMATION			
Social Security Number of Insurance Plan Subscriber:			
Is this patient covered by insurance? ❑ Yes ❑ No	Is this person responsible for the bill a patient here? ❑ Yes ❑ No		
Subscriber/Person responsible for bill:	Birth date: / /	Address:	Home phone no.: ( )
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Medical and Vision Insurance

We are only contracted with the Following plans listed below; please check the plan you currently carry.

- **Medical Plans:** ❑ Medicare (Red, White and Blue Card) ❑Medicaid/Carolina Access ❑ BCBS Plans ❑Medcost ❑United Healthcare ❑Blue Medicare HMO ❑Aetna ❑Humana
- **Vision Plans**: ❑ Community Eye Care ❑ EyeMed ❑VSP

We do not accept HMO plans (except blue Medicare). Medicare plans forward to your secondary plan, if not, we will file as a courtesy. We file Tricare as a courtesy.

You must have a referral from your Primary Care Physician before your appointment if you have Tricare Prime.

Please make us aware of which Medicaid plan you currently have as we are not contracted with all of them.

Please sign to confirm you carry the plan indicated on this form. Last Revised 01/26/2023

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 unpaid balance and non-covered services as reported by my insurance. This includes but is not limited to Refractions and special testing. I authorize Western Carolina Eye Associate, PA, or insurance company to release any information required to process my claims.

_____ _____

Western Carolina Eye Associate, PA

Privacy Practices and Shared Information Agreement

Name:_____Phone:_____Date of Birth:_____/_____/_____

Notice of Privacy

Please review WCEA Notice of Privacy Agreement which adheres to HIPAA guidelines.
The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- WCEA has a Notice of Privacy Practices, and any patient may review it anytime.
- WCEA reserved the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but WCEA does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent.
- WCEA may condition treatment upon the execution of this consent.

Shared Information Agreement

Many of our patients allow family members such as their spouse, parents, or friends to call and request medical or billing information. If the patient is a minor, please include all parent/legal guardian information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent.
If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. I authorize Western Carolina Eye Associates, P.A. to release my medical and/or billing information to the following individual(s):

1. _____ Relation:_____ ☐ Billing ☐ Medical
2. _____Relation:_____ ☐ Billing ☐ Medical
3. _____ Relation:_____ ☐ Billing ☐ Medical

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclose by the above recipient. You have the right to revoke this consent in writing.

I acknowledge that I have received a Notice of Privacy Practices and the Shared information Agreement in accordance with HIPAA guidelines. I agree to the terms and conditions listed above. The above information is true to the best of my knowledge.

_____ _____
Patient/Guardian Signature Date