Northridge Eye Care 530 Main Street Red Bluff, CA 96080-3455
Phone: (530) 529-1750 FAX: (530) 435-6074 www.northridgeeyecare.com

Patient Registration

07/09/2024

Please review, make necessary changes and supply any missing information.

Patient Name					**SS #**		
Date of Birth		**Age**		**Gender**			
Address							
Address Type				**Country**			
Home Phone #		**Work Phone #**			**Extension**		
Cell Phone #		**Email**					
Occupation		**Employer**					

Government Required Information			
Primary Language	English	**Communication Preference**	☐ Phone Cell ☐ Phone Home
Race	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined to Specify		
Ethnicity	Not Hispanic or Latino	If not correct please choose:	☐ Not Hispanic ☐ Hispanic or Latino ☐ Declined to Specify

ACCOUNT RESPONSIBLE					
Responsible			**Relationship**		
SS #					
Address					
Home Phone #		**Work Phone #**		**Extension**	

ASSIGNMENT OF BENEFITS

I understand that Northridge Eye Care will bill my medical insurance carrier for covered services. If Northridge Eye Care is not contracted with my insurance plan, payment will be due at the time of service, and I will be provided with an itemized statement with which I can bill my insurance carrier.

- I authorize and request that insurance benefits be made directly to Northridge Eye Care on my behalf for all services furnished to me by any physician employed at Northridge Care or its affiliates.
- I am aware that I am responsible for the deductible, coinsurance and any non-covered services. Coinsurance and deductibles are based upon the change determination of my insurance carrier/carriers.
- If I do not have insurance, I understand that payment will be due at the time of service.
- I understand that I am financially responsible for all charges whether or not paid by my insurance.

RELEASE OF INFORMATION

Insurance authorization, release of medical records, insurance benefits and assignments, responsibility of patient and acknowledgment

- Northridge Eye Care, employees of its Medical Staff (including your physician), and the independent contractor services have agreed, as permitted by law, to share your health information among themselves for the purposes of treatment, payment or health care operations. This enables us to better address your health care needs. This information is being provided to you as a supplement to The Notice of Privacy Practices given to you by Northridge Eye Care. For the purposes of treatment, payment, or health care operations, I authorize the release of all medical records and any insurance information between Northridge Eye Care, its affiliates, my family physician, insurance carriers and the Health Care Financing Administration to process claims for related services.
- I hereby authorize said assignee to release information necessary to secure payment.
- I allow for fax transmission and electronic submission of such information.
- A scan and/or photocopy of this assignment will be considered as valid as an original.

CONSENT FOR TREATMENT

I have read and fully understand the above consent for evaluation and treatment, financial responsibility, release of medical information and insurance authorization.

Signature of Patient / Parent / Guardian / Conservator _____ Date _____ Reason Patient is unable to sign _____

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Acknowledgement Of Privacy Practices

July 9, 2024

I, _____ acknowledge that I have received a copy of the Notice of Privacy Practices from Northridge Eye Care.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Phone Number