Registration (Please Print)

Date_____ Soc.Sec.#_____/_____/_____ Sex_____ E-mail_____

Patient's Name_____ Birthdate_____/____/_____

Home Address_____City_____State____Zip_____

Preferred Phone ( )_____-_____ ☐ Home ☐ Cell ☐ Work Secondary Phone ( ) _____-_____ ☐ Home ☐ Cell ☐ Work

□ Single □ Married □ Widowed □ Divorced Person To Pay Account_____

Primary Insurance_____ ID#_____

Name of Insured_____ Insured Date of Birth___/___/___ Soc. Sec. #_____/____/_____

Secondary Insurance_____ ID#_____

VSP (Vision Service Plan) □ Yes □ No Insured Name_____Date of Birth___/___/___
ID #_____/____/_____ or last 4 #'s of SS# -_____

Referred by_____

Emergency Contact Person _____Phone # _____- _____

I have read the Altos Eye Physicians Notice of Privacy Practices. I assume responsibility for my account.
I authorize you to release any information regarding my care and treatment to_____.
Relationship to patient _____

Signed _____ ☐ Patient ☐ Parent/Guardian ☐ Other _____

Altos Eye Physicians Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Altos Eye Physicians, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.
You may request in writing that we do not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at 650-948-9123.

This notice goes into effect as of January 1, 2016.