PRIMARY EYECARE ASSOCIATES

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____

Date of Birth: _____Social Security #: _____ Gender: Male Female

Address: _____ City: _____State: _____ Zip: _____

Cell Phone: _____Home Phone: _____

Email: _____

Primary Care Physician: _____

VISION INSURANCE INFORMATION – Insurance Policy Holder is who the insurance is through. If it is Patient, please put **SAME** below.

Primary Vision Insurance: _____ Policy Holder Name: _____

Policy Holders Date of Birth: _____ Policy Holders Last 4 Digits of Social Security #: _____

Secondary Vision Insurance: _____ Policy Holder Name: _____

Policy Holders Date of Birth: _____Policy Holders Last 4 Digits of Social Security #: _____

MEDICAL INSURANCE INFORMATION - – Insurance Policy Holder is who the insurance is through. If it is Patient, please put **SAME** below.

Primary Medical Insurance: _____ Policy Holder Name: _____

Policy Holders Date of Birth: _____Policy Holder Employment Status: Employed Retired

Relationship to Patient: Self Spouse Child Other

Secondary Medical Insurance: _____ Policy Holder Name: _____

Policy Holders Date of Birth: _____Policy Holder Employment Status: Employed Retired

Relationship to Patient: Self Spouse Child Other

INSURANCE ASSIGNMENT AND RELEASE OF PAYMENT

Assignment and Release I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to realize all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Date: _____

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice of before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability act of 1996 (HIPPA).

The Patient Understands that:

Protected Health Information may be disclosed or used for treatment, payment, or health care operations.

- The Practice has a Notice of Privacy Practices, and the patient can review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to restrict the use of their information, but the Practice 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.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by –

Print Name (Patient or Representative): _____

Signature: _____Date: _____

Diabetic/Medical Exams

If your eye exam requires a full medical workup or ancillary testing due to a diagnosis of Diabetes or other medical conditions and factors of your current medical history, your MEDICAL INSURANCE plan including a supplement plan if you have one, will be billed. You will be responsible for any copays, coinsurance and if your annual deductible is not satisfied, you are responsible for the balance due.

Signature:_____ Date:_____