Eye Center of St. Augustine

PATIENT INFORMATION

____
First Middle Last, Suffix

Address: ______________________________

________ ________ ________
City State ZIP

SSN: ____________ Circle: Single/Married/Other

DOB: ____________ Circle: Male/Female

Check the boxes for you preferred contact means:

☐ Mobile Phone: ______________________

☐ Home Phone: ______________________

☐ Email: ______________________

Preferred Contact: ______________________

Emergency Contact: ______________________
First Last

Relationship: ______________________

Phone: ______________________
☐ Mobile ☐ Home ☐ Work

Circle: Employed | Student

Occupation: ______________________

Company or School: ______________________

Address: ______________________

________ ________ ________
City State Zip

Race: ☐ Asian ☐ African American ☐ Hispanic/Latino
☐ Caucasian ☐ Other: ____________

Preferred Language: ☐ English ☐ Spanish ☐ ASL
☐ Other: ____________

Primary Care Physician: ______________________

Referral Source: ______________________

Referred by Patient: ☐ Yes ☐ No

POLICY HOLDER INFORMATION

____
Prefix Title Suffix

____
First Middle Last

Address: ______________________________

____

________ ________ ________

City State Zip

Employer/School: ______________________
DOB: ______________
SSN: ______________
Phone: ______________________

Patient Relationship to the Policy Holder:

____

Gender of Insured Party: ☐ Male ☐ Female

Responsible Party: ☐ Patient ☐ Policy Holder ☐ Other

INSURANCE INFORMATION

Do you have medical insurance? ☐ Yes ☐ No Do you have vision insurance? ☐ Yes ☐ No

Insurance: ______________________________ Effective Date: ______________________
Policy No.: ______________________

Insurance: ______________________________ Effective Date: ______________________
Policy No.: ______________________

*****PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST*****

Eye Center
of St. Augustine

AUTHORIZATIONS

- I hereby authorize and request the medical treatment necessary for the care of the above patient.
- I authorize the EYE CENTER OF ST. AUGUSTINE to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to the referring and family physicians and to my insurance company. If necessary, I allow the fax transmittal of my medical records.
- I acknowledge full financial responsibility for services rendered at the EYE CENTER OF ST. AUGUSTINE. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my charges.
- I further authorize and request that insurance payments be made directly to EYE CENTER OF ST. AUGUSTINE if they elect such an arrangement.
- I acknowledge that I have received a notice of the Notice of Privacy Practices. A copy is in the front of the office.
- I acknowledge my email may be used solely to relay information regarding appointments, non-critical test results, or other general information.
- Patients, patient representatives, or visitors that elect to record an exam visit hereby acknowledge and accept among other risks, that the recording may not provide the opportunity for a third party to pose questions to the provider/staff and that certain nonberal communications may be captured by the recording.
  Under no circumstances may a patient, patient representative, or visitor take a recording of another patient, patient representative, or visitor without explicit permission.
- **** This policy is not applicable to patients, patient representatives, or visitors in (California, Connecticut, Floirda, Illinois, Maryland, Massachusetts, Michigan, Montana, Nevada, New Hampshire, Pennyslvania, and Washington). In the states, undisclosed recordings, on the part of physicians or patients, are prohibited by law, as everyone being recorded must consent.**
- I certify that the information I have provided is true and accurate, and I understand and agree to all the patient responsibilities previously outlined.

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

____ ________________________

Patient / Parent or Guardian Signature Date

Eye Center
of St. Augustine

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (please print): ______________________ **Date of Birth:** ______________________

This form does not apply to other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (which are allowed by federal law), and workers compensation agencies. We cannot release ANY of your medical information to any person or organization (including family members, spouse, etc) unless you list their names below.

I give permission to the Eye Center of St. Augustine to discuss the following medical and billing informaiton about me **(check all that apply)**:

- ☐ Scheduling/Appointment Information
- ☐ Medical Information (including symptoms, diagnoiss, medications and treatment plan)
- ☐ Laboratory/Test Results
- ☐ Financial Details/Payment Information
- ☐ All of the Above
- ☐ Other: ______________________

The Eye Center of St. Augustine has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may revoke or terminate this permission at any time by submitting a written revocation to the Eye Center of St. Augustine. I will contact the Eye Center of St. Augustine. Privacy Contact in writing to terminate the authorization.

- ☐ This authorization expires:
- ☐ No expiration date
- ☐ Date specified ____ / ____ / ____ - unless revoked or terminated in writing by you or your patient personal representative.
- ☐ I decline permission to discuss medical information

______________________ ______________ ______________________

Signature of Patient/Guardian Date Relationship to Patient

______________________ ______________

Staff Member Date