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