Cornea & Cataract
specialty center

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE # (_____) _____ CELL PHONE # (_____)_____

SEX: [ ] MALE [ ] FEMALE [ ] PREFER NOT TO ANSWER RACE:_____ ETHNICITY: _____

EMPLOYER: _____ WORK PHONE #:_____

EMAIL ADDRESS:_____

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

IF MARRIED, WHAT IS YOUR SPOUSE'S NAME: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE # (_____) _____

HOW DID YOU HEAR ABOUT US:

_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE:_____

POLICY HOLDER:_____ POLICY HOLDER:_____

MEMBER ID:_____ MEMBER ID:_____

GROUP #: _____ GROUP #:_____

POLICY HOLDER'S DATE OF BIRTH:_____ POLICY HOLDER'S DATE OF BIRTH:_____

PHYSICIAN (S) INFORMATION

REFERRING PHYSCIAN: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

ANY OTHER PHYSICIAN INVOLVED IN YOUR CARE: _____

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- Practice has the right to restrict the use of the information, but our practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or send you a text to confirm your appointment? YES NO

May we leave a message on your voicemail at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If you answered yes to the question above, please list the name of the authorized person (s)

_____

Signature: _____ **Date:** _____

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PATIENT FINANCIAL RESPONSIBITY FORM

At Lasik, Cornea & Cataract Specialty Center, we strive to give you the best possible care. To serve this purpose, it is important that you understand the process of reimbursement. Please read this financial responsibility form and sign at the bottom to acknowledge that you understand your accountability.

Insurance Coverage:

It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusions and limitations, and authorization requirements. This information can be obtained by contacting your insurance company. We attempt to verify that your coverage is valid at the time of your visit, however, if your coverage is not in effect at the time of the visit, the financial responsibility for any payments due will be yours.

IF YOU HAVE HAD ANY CHANGES IN YOUR INSURANCE COVERAGE, YOU MUST TELL US

Copayments, Co-Insurances, and Deductibles:

Co-payments and co-insurance are your responsibility. Your insurance company expects us to collect them from you at the time of service. Please understand that you will be expected to pay your co-payment or co-insurance for every date of service. You are responsible for your deductibles. The deductible is determined by your individual contract with your insurance company. We may not have information about each person's deductible amount, or how much of it has been met. You will be responsible for finding out all information regarding your deductible prior to your appointment with our office.

Self-Pay (private pay):

All self-pay patients and patients presented without valid insurance information are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment when you check in for your appointment. Should you have insurance but are unable to provide valid information at the time of your visit, you will be expected to pay in full at the time of service until your insurance information is on file.

Signature: _____ **Date:** _____