PATIENT INFORMATION FORM

PATIENT LEGAL NAME_____

SS#_____SEX_____DOB_____

MARITAL STATUS: ___SINGLE ___MARRIED ___WIDOWED ___DIVORCED

****NEW INFO REQUIRED BY FEDERAL ELECTRONIC HEALTH REGULATIONS****

RACE ___ AMERICAN INDIAN OR ALASKA NATIVE ___ ASIAN ___ CAUCASIAN
___BLACK OR AFRICAN AMERICAN ___ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

ETHNICITY ___ HISPANIC/LATINO ___ NOT HISPANIC/LATINIO

PREFERRED LANGUAGE_____

HOME PHONE#_____WORK#_____CELL#_____

E-MAIL ADDRESS_____

HOME ADDRESS_____

CITY_____STATE_____ZIP_____

EMPLOYER:_____

OCCUPATION_____

EMERGENCY CONTACT_____

PHONE_____CELL_____WORK_____

INSURANCE INFORMATION

INSURED LEGAL NAME_____

RELATIONSHIP TO PATIENT_____

SS#_____DOB_____ (FOR INSURANCE PURPOSES)

MEDICAL INFORMATION

PRIMARY CARE (Family Doctor) _____

ENDOCRINOLOGIST_____

PRFERRED PHARMACY_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

OPTOMETRIST_____

FRIEND/FAMILY_____

OTHER_____

NORTH COLUMBUS EYE CENTER

AGREEMENT OF RESPONSIBILITY

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for all charges not covered by my insurance company.

CONSENT TO TREAT

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize use of this form on all my insurance submission and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due me.

I hereby authorize North Columbus Eye Center, its agents, employees, and affiliates to have access to my complete medical records for the purpose of performing its management functions and as they deem necessary.

I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item nine of the CMS-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and the uncovered service. C0-insurance and the deductible are based upon the charge determination of the Medicare carrier.

PRIVACY NOTICE

I understand I have the right to review North Columbus Eye Center, Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of North Columbus Eye Center.

I acknowledge that I received a copy of North Columbus Eye Center's Notice of Privacy Practices.

PATIENT NAME (PLEASE PRINT) _____

SIGNATURE_____DATE_____