

Date: _____

Name: _____ Birthdate: _____
MR / MRS / MS / MISS LAST FIRST M.I.

Your Relationship to Insured: Self Spouse Dep Other _____ Sex: _____

Address: _____
STREET APT. # CITY STATE ZIP CODE

Home Ph. _____ Work Ph. _____
() ()

Cell Ph. _____ Preferred Contact: Home Cell Work
()

E-mail: _____

Language: _____ Race: _____ Ethnicity: _____

Emergency Contact and # _____

Occupation: _____ Who referred you to our office: _____

Was referral by a physician? Yes No If yes, please provide referring physician's name and address:

LAST FIRST CITY STATE

ABOUT YOUR VISION

Are you interested in receiving information about laser vision correction for improving your vision without glasses or contacts?

Yes No

Do You Wear Contact Lenses?

Yes No

Do You Sleep in Your Contact Lenses?

Yes No

Do You Wear Glasses?

Yes No

Age of Present Glasses: _____

When do you wear glasses or contacts?

Reading

Distance

Computers

Sports

Playing Musical Instruments

Other: _____

Who is your current eye doctor? _____

INSURANCE INFORMATION

Primary

Insurance Co.: _____

Policy #: _____

Group # _____ Plan # _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____

Copay: _____

Deductible: _____

Secondary

Insurance Co.: _____

Policy #: _____

Group # _____ Plan # _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____

Copay: _____

Deductible: _____

Use and Disclosure of Protected Health Information

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

Washington Eye Physicians & Surgeons' **Notice of Privacy Practices** provides information about how our practice might use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability Act of 1996 (HIPAA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, a notice will be prominently posted in our offices.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

Patient's Signature

Print Full Name

Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Washington Eye Physicians & Surgeons, PC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements.

Patient's Signature

Print Full Name

Date

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.