HIPAA / Insurance Consent Form

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:___ Birthdate: ____/____/_____ Age_____

Address:_____ City:_____ State:____ Zip:_____ SSN:_____--_____--_____

Home Phone:_____ Work Phone:_____ Cell:_____

Marital status:___single ___married ___widowed Sex: ___M ___F Email:_____

Primary care physician_____Phone:_____Fax:_____

Previous eye doctor_____ If new patient, Referred by:_____

PRIMARY INSURED (Guarantor) Information ___check here if same as patient

Last Name:_____ First Name:_____ MI:___ Birthdate: ____/____/_____

Address:_____ City:_____ State:_____ Zip:_____ SSN:_____--_____--_____

Home Phone:_____ Work Phone:_____ Cell:_____

Relationship to patient __mother __father __spouse __domestic partner __step parent __legal guardian

INSURANCE

Vision Insurance:_____ ID#_____

Medical Insurance:_____ ID#_____ Group#_____

Address:_____ City:_____ State:___ Zip:_____ Customer Service_____

Employer:_____

I must provide any information necessary to determine my benefits. I authorize the release of any medical or personal information necessary to process insurance claims and secure payment. I request Medicare and/or insurance benefits to be assigned to the provider for any and all services or materials received by me. The assignment will remain in full effect unless revoked by me in writing. In the event, my insurance coverage is inactive or the insurance does not pay the balance in full, I understand that I will by financially responsible for any unpaid balance. It is my responsibility to pay and deductible, copays, co-insurance, or other balance not paid my insurance.

I understand that vision insurance only covers a routine eye test. In the event that I have any eye medical condition, which may include but is not limited to: eye allergies, dry eyes, eye infections, glaucoma, diabetes, hypertension, and headaches Sharp Eyes reserves the right to bill my medical insurance.

Name:_____Signature:_____ Date:___/___/_____

HIPAA is a privacy standard that was enacted by the Dept of Health and Human Services, to protect your personal health care information. According to HIPAA, Sharp Eyes may collect and disclose certain personal information about you in order to facilitate treatment , payment, and maintain health care operations. Health care operations may include but are not limited to the utilization of my personal health information for activities such as the filing of insurance claims and/or to call, write, or email me regarding important health related issues. Our Notice of Privacy Practices (NPP) details all of the uses and disclosures that may occur with your health information. Sharp Eyes does not release your information for outside marketing. Our complete NPP is prominently displayed in our office and is also available on our web site at www.sharpeyesvisioncenter.com. You may also request a hard copy of our NPP to take with you.

I authorize the sharing of my health information with the following individual(s):_____

I give permission to be contacted by Sharp Eyes via mail, email, phone, fax, and/or text. I also give permission to leave a message at the phone or cell # designated above if I'm not able to answer the call. I understand that email and texting is not a secure means of communication.

I acknowledge review or receipt of a copy of Sharp Eyes' NPP:

Name:_____Signature:_____ Date:___/___/_____