

Pharmacy:	Family Physician:
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PATIENT INFORMATION

Patient's Last Name:		First:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital status (circle one):	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Widow	
Home Phone:	Cell Phone:	Work Phone:		Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			P.O. Box:	E-mail Address:		
City:			State:	ZIP Code:	Social Security #:	
Occupation:		Employer Address:		Employer:		
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital						
<input type="checkbox"/> Family/Friend <input type="checkbox"/> Location <input type="checkbox"/> Newspaper <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____						
Other family members seen here:						

INSURANCE INFORMATION

Vision Insurance: <input type="checkbox"/> None <input type="checkbox"/> BCBS <input type="checkbox"/> Davis <input type="checkbox"/> EyeMed <input type="checkbox"/> Medicaid <input type="checkbox"/> PHP <input type="checkbox"/> VSP <input type="checkbox"/> Other _____			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Person responsible for bill if not patient:	Birth Date:	Address (if different):	
		Home Phone:	
Occupation:	Employer:	Employer Address:	Employer Phone:
Please Check Name of Primary Insurance			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Blue Cross/Blue Shield (BCBS) <input type="checkbox"/> Medicare Plus Blue	<input type="checkbox"/> Blue Care Network (BCN) <input type="checkbox"/> Physician Health Plan (PHP)	<input type="checkbox"/> Blue Care Advantage <input type="checkbox"/> Humana <input type="checkbox"/> McLaren <input type="checkbox"/> Other: _____
Subscriber's Name:		Subscriber's Social Security #:	Birth Date:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Please Check Name of Secondary Insurance			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Blue Cross/Blue Shield (BCBS) <input type="checkbox"/> Medicare Plus Blue	<input type="checkbox"/> Blue Care Network (BCN) <input type="checkbox"/> Physician Health Plan (PHP)	<input type="checkbox"/> Blue Care Network Advantage <input type="checkbox"/> Humana <input type="checkbox"/> McLaren <input type="checkbox"/> Other: _____
Subscriber's Name:		Subscriber's Social Security #:	Birth Date:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone:	Work Phone:
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Standing Release of Personal Health Information: In most instances, Clinton Ophthalmology cannot legally provide personal health information to anyone including family members without your express written consent. This includes appointment times and test results. Please list any individuals to whom you authorize Clinton Ophthalmology to release your health information. This authorization will remain in effect until such time you rescind the authorization in writing. Please be sure to include the birth date so we can verify the individual's identity.

Name	Relationship	Phone Number	Birth Date
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Clinton Ophthalmology, PC or insurance company to release any information required to process my claims.			
_____ Patient/Guardian Signature			_____ Date

Please Initial:

_____ **CONSENT FOR TREATMENT:** I authorize Brandy Cook, DO or designees to perform routine diagnostic procedures and medical treatment.

_____ **VOICEMAIL:** I authorize Clinton Ophthalmology to leave messages on voicemail and/or answering machine.

_____ **PAYMENT AGREEMENT & ACKNOWLEDGEMENT:** I understand that my copay, co-insurance, and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable copays and deductibles are my responsibility. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree to pay in full within 15 days of receipt of notice all balances due not paid by my insurance company in addition to any fees charged against my account.

_____ **MEDICARE ONE TIME AUTHORIZATION AGREEMENT:** I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Clinton Ophthalmology, Dr. Brandy Cook. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services. For services furnished by a provider, or on an outpatient basis, this request is effective until revoked by the beneficiary. If a patient objects to part of the request for payment, the provider should annotate accordingly.

_____ **COMMERICAL INSURANCE RELEASE:** I hereby authorize the release to my insurance company (s), or their designee, any medical information necessary to properly process by bill (including any information that may be contained in the records pertaining to AIDS, or HIV antibody). I authorize payment of medical benefits to be made to the providers for services rendered. I have read and understand the above agreement.

_____ **PRIVACY PRACTICES ACKNOWLEDGEMENT:**

- I acknowledge that: A copy of Clinton Ophthalmology, PC notice of privacy practices was made available to me at the location where I received health care services
- The Notice of Privacy Practice was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.
- I know that I can ask for a copy of the notice of Privacy Practices to take with me.
- If I came in for health care services under an emergency treatment situation, I was able to view the Notice of Privacy as soon as reasonably practical after the emergency treatment

By affixing my signature below, I certify that I have read, understood, and initialed the above agreements. I have been given an opportunity to ask any questions regarding these agreements/acknowledgements.

Patient Name (Please Print)

Patient's Signature

Date

Responsible/Authorized Representative (Guarantor)

Relationship to Patient

Guarantor Signature

Date

Clinton Ophthalmology, PC has verified the identification of _____ (Patient Representative) by _____ (Type of Identification) and his/her capacity of _____ (Description of Authority). Verification completed by: _____ (Associate Printed Name/Signature/Date)