CLINTON OPHTHALMOLOGY

Pharmacy	Family Physician

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth

Home Phone	Cell Phone	Work Phone	Sex
			❑ M ❑ F

Address	PO Box	Marital status (circle one)
		Single / Mar / Div / Sep / Widow

City	State	Zip Code	Social Security #

E-mail Address:	Are you a Student?	Work-related visit?
	❑ Yes ❑ No	❑ Yes ❑ No

COMPLETE IF YOU HAVE MEDICARE

Are you eligible for black lung benefits? ❑ Yes ❑ No	Are you paid by a government research program? ❑ Yes ❑ No
Are you eligible for Medicare based on disability? ❑ Yes ❑ No	Are you entitled to benefits though the VA? ❑ Yes ❑ No

Are you eligible for Medicare based on End Stage Renal Disease ❑ Yes ❑ No

RESPONSIBLE PARTY IF NOT PATIENT

Name	
Address	
Home Phone	Cell Phone

INSURANCE INFORMATION

Vision Insurance ❑ None ❑ BCBS ❑ Davis ❑ Eye Med ❑ Medicaid ❑ PHP ❑ VSP ❑ Other _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Primary Insurance Carrier

Subscriber's Name	Subscriber's Social Security #	Birth Date

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Secondary Insurance Carrier

Subscriber's Name	Subscriber's Social Security #	Birth Date

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Home Phone	Work Phone

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***

CLINTON OPHTHALMOLOGY

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 ACKNOWLDGEMENT:**

- 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)