Date_____ Last _____MI____First_____

Address_____ City_____ St____ Zip_____

Primary Contact Phone_____-_____-_____ Secondary Phone ____-____-_____ Cell phone ____-____-_____

Birth Date_____ Social Sec #____-____-_____ Email_____ Age_____

Male ☐ Female ☐ Marital Status____ Race_____ Ethnicity_____ Person Resp for Payment_____

Employer_____ Medical Insurance company_____

If you have VISION INSURANCE, list type & ID #_____

How did you hear about us? _____ Occupation_____

Did another doctor refer you for an eye examination? Y/N (if yes) Dr._____

PLEASE NOTE: We are providers for some insurance programs. Please consult your insurance plan for details regarding deductibles and maximum payments. Some procedures and materials are medically necessary, but may not be covered by insurance. These services are the responsibility of the patient. ALL insurance and Discount cards must be **PRESENT AT THE TIME OF EXAMINATION**. Patients are responsible for all charges not paid by insurance. I authorize payment of benefits for service and assume responsibility for all charges.

I authorize the release of information necessary to my insurance claim(s). **I UNDERSTAND PAYMENT IS DUE AT THE TIME OF SERVICE.**

SIGNED: _____Date_____ (Please state relationship if signing for a minor) _____

Eye Health Authorization for Medical Record Release

Patient Name: _____ DOB: _____

Current Phone: _____

☐ I hereby authorize: Eye Health of Somerset
165 Parker's Mill Way
Somerset, KY 42503

or

Eye Health of Stanford
713 E Main St
Stanford, KY 40484

Release My Information To:

1) Name: _____
Address: _____
Phone: _____ Fax: _____

2) Name: _____
Address: _____
Phone: _____ Fax: _____

Records to be released: ___ All or ___Dates:_____

OR

☐ I do not wish ANY records/materials to be released to anyone other than myself. A photo ID will be provided for my verification.

Your records may be faxed or mailed to the location(s) listed above. If preferred we will send your records via the patient portal administered through our secure web system. Regardless of relation, (unless a guardian of a minor or ward) records/materials will

NOT BE RELEASED

to anyone NOT listed above, or on additional sheets of consent. (i.e.: husband/wife…adult parent/child…etc.). If you wish a spouse, child, parent, extended relative, or persons other than mentioned to receive your records/materials, you must provide us with their information prior to releasing any records. Please note, a signed form, listing recipient information and a photo ID of receiving parties will be required if records are released to persons other than the patient.

We provide the past two years of electronic records free of charge to the patient or another physician. After first record release the patient is responsible for copying/ handling fees for any additional records released. A fee of $25.00 will be required prior to records release or before any copies are made.

Upon request, I may revoke this authorization in writing at any time. I understand the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization and know that I can still be treated for my vision and medical needs. Photocopies of the original are to be considered the same as the signed original documents. This authorization upholds the regulations dictated in Section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation act of 1987 and of Section 408 of the Drug Abuse Office and Treatment act of 1972.

Signature: _____ Date: _____

Relationship to patient (if parent or guardian): _____

HIPPA **Date** _____

Eye Health of Somerset
165 Parkers Mill Way
Somerset, KY 42503

or

Eye Health of Stanford
713 East Main Street
Stanford, KY 40484

I _____, have received/been offered a copy of HIPPA guidelines. This is the notice of privacy act in accordance to national and state guidelines. I realize that at any time I may request to receive another copy of the Notice of Privacy Practices and one will be provided to me.

_____

(signature)