Patient Information

Name ____ Date of Birth _____/_____/_____

Address____ City_______________ Zip___________

SS# _______-_______-_______ Email____

Phone (____)_________________ Cell (____)_________________ Work (____)_________________

Occupation _______________________ How did you hear about us? __________________________

Texting YES /NO Primary Care Physician ____

Spouse or Parent(s) Name(s) ____

Pharmacy (please include town) ____

Medication Allergies ____

Insurance Information

Insured member Name ____

Date Of Birth _____/______/_____ SS# ______-______-______

Relationship to Patient ________________________________

Address (if different from Patient)____

Protected Health Information (PHI) refers to information that we have that is related to your medical records. This does include date of birth, exam notes, test results, and pharmacy information. In order to better serve you we need your consent to send information electronically. This can include electronically to you as well as pharmacies. If you do NOT want us to share your information please mark the following box. If you consent to us sharing please do nothing in the box.

_____ DO NOT SHARE

Please note any people we may share your information with. If patient is under 18 years of age, the natural parents or legal guardians have rights to the records. Step-parents however do need to be added. We will not contact these people they must contact us.

__________________________________ __________________________________

__________________________________ __________________________________

- I understand and authorize the use of this form on all my insurance submissions and authorize the release of information needed to process a claim to all of my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment for services from my insurance company for services and goods that have been provided by the provider. I understand that the provider does not accept responsibility for services not covered by my insurance plan and that I am financially responsible for any services provided that are not covered under my insurance plan. I understand that my insurance company will pay the provider directly and then the provider will send me a bill for services not provided.
- This agreement will be in effect until two years from below date.
- I acknowledge I have read and reviewed the HIPPA privacy act in regards to my PHI and authorize this provider to all of the above.
- I request that all insurance payments be made to Bethalto Family Vision Care for any services furnished to me. I understand that my signature states that I am financially responsible for any cost that my insurance and co-insurance does not cover and I will be charged accordingly.

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Signature of Patient Date