MIDWEST EYE CENTER S.C.

Patient information

(PLEASE PRINT)

Name:_____Social Security: _____
Birth date: _____ Female/Male Single/Married/Widowed/Divorced/Separated
Address: _____City:_____State:_____Zip:_____
Cell Phone:_____Home Phone:_____Email:_____
Employer:_____ Work Phone:_____
Ethnicity: Hispanic/Non Hispanic
Race: Black/ White/ Asian/ Native Hawaiian/ Pacific Islander/ American Indian/ Alaskan Native/ Other

Emergency Contact Information

Emergency Contact:_____Phone #:_____
Relationship to Patient:_____
Primary Care Physician: _____**Phone/FAX #:**_____
Pharmacy**:**_____**Phone/FAX #:**_____

Authorization to Bill Insurance

Since Midwest Eye Center will bill on my behalf for payment, I authorize payments directly to the physician of surgical and/or medical benefits. I understand I am responsible for any portion of my bill not covered by my insurance. I also authorize release of information for insurance claim purposes. **Copayments, deductible, and self-pay patient balances are due at the time services are rendered.** I understand all of the above and hereby state that the information given is correct. My signature indicates that I have read the above and grant the request of authorizations.

Date:_____Signed _X_____
Self /Parent/ Guardian

HIPPA CONSENT

I, _____, herby give my consent to Midwest Eye Center S.C. to use or disclose, for the
(Self, Parent, Guardian)
purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____. (Patient Name)

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

I authorize my health care provider to use an automated telephone system and/or email to use my name, address, and phone number, treating physician, and time and place of my scheduled appointment, for the limited purpose of contacting me about a pending appointment, cancellation, or other healthcare related communications. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail or answering machine.

Signature: _____Date:_____
Person(s) Authorized for release of records/Information:

_____

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