New Patient Information
(PLEASE PRINT)

PATIENT INFORMATION

First Name Middle Last Name Social Security Number

Address City State Zip Code

Date of Birth_____ Age_____ Sex_____ Marital Status_____

Race: Caucasian African American Latino Asian Other Refuse
Circle One

Ethnicity: Hispanic Non-Hispanic Refuse
Circle One

Home Phone # (_____)_____ Cell Phone # (_____)_____

Email address: _____

Employer: _____ Work #_____

Emergency Contact:_____ Emergency # _____

RESPONSIBLE PARTY (if different from patient or if patient is under 18)

First Name Middle Last Name Social Security Number

Address City State Zip Code

Home Phone # (_____)_____ Cell Phone # (_____)_____

Date of Birth: _____ Relationship to Patient: _____

Patient Employer: _____ Work Phone # (_____)_____

INSURANCE INFORMATION:

Primary Insurance Policy # Group/Plan #

Insured's Name Insured's Date of Birth Relationship to Patient

Secondary Insurance Policy # Group/Plan #

Insured's Name Insured's Date of Birth Relationship to Patient

(COMPLETE REVERSE SIDE)

INSURANCE ASSIGNMENT AND CONSENT FOR TREATMENT

I hereby authorize Auburn Cataract and Eye Clinic, LLC to give my insurance company or companies, my attorney, or my physician, any and all information they may require concerning my visit/treatment. I hereby assign to the clinic all Medicare and/or other payments made on my behalf for treatments furnished to me. I understand that I am responsible for all charges not covered by insurance, including a NO-SHOW charge of $25 for appointments not cancelled or rescheduled at least 12 hours before my appointment time. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State. You agree, in order for us to service your account or to collect monies you may owe, Auburn Cataract and Eye Clinic and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. This assignment will remain in effect until revoked by me in writing. I further authorize the Physician and the staff of Auburn Cataract and Eye Clinic, LLC to examine my eyes and perform any services normally associated with an eye examination.

*****I/We have read this disclosure and agree that Auburn Cataract and Eye Clinic, LLC, its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature Date

NOTICE OF PRIVACY

- I give the practice consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.
- I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before consigning this consent.
- I understand that this practice has the right to change their privacy practices and that I may obtain any revised changes upon request.
- I understand that I have the right to request a restriction of how my protected healthcare information is used. I also understand that I may evoke this consent by making a request in writing, except for information already under use or disclosed.

YOU MAY DISCUSS MY MEDICAL CONDITION AND/OR RELEASE COPIES OF MY MEDICAL RECORD TO THE FOLLOWING:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

[ ] ***I GIVE*** permission to electronically access prescription medication history from pharmacies that participate in E-prescribing.

[ ] ***I DO NOT*** give permission to electronically access prescription medication history from pharmacies that participate in E-prescribing.

Signature:_____ Date:_____