EYE CARE *Specialists*, L.L.C.

PATIENT INFORMATION

PATIENT'S FULL NAME _____

Social Security# _____ Birth Date _____ Sex ☐ Male ☐ Female

Address _____ City/State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Email _____

Other Contact (Friend/Neighbor/etc.): _____ Phone _____

Who should be notified in an Emergency? _____

Relationship to patient _____ Phone _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name _____

Work/School Status: ☐ Employed ☐ Retired ☐ F/T Student ☐ P/T Student ☐ N/A

Occupation _____

Employer / School Name _____

Employer / School Address _____

If patient is a minor/child, please list Parent/Legal Guardian

Father _____ DOB: _____ Social Security # _____

Address _____

Employer _____ Occupation _____ Phone _____

Mother _____ DOB: _____ Social Security # _____

Address _____

Employer _____ Occupation _____ Phone _____

PRIMARY INSURANCE PLAN _____ Effective Date _____

Policy / Patient ID _____ Group IL (if any) _____

SECONDARY INSURANCE PLAN _____ Effective Date _____

Policy / Patient ID _____ Group IL (if any) _____

If any insurance policy is in the name of an individual other than the patient's name (i.e. spouse, parent, etc.) please provide the following:

Name _____ Birth Date _____

Address _____

Relationship to Patient _____ Phone _____

Social Security# _____ If patient is a minor, who is responsible for payment? _____

Who referred you to see us? _____

Have other members of your family been seen by us? ☐ Yes _____ ☐ No

Patient Signature (or Legal Guardian) _____ Date _____

EMAIL PRINT

EYE CARE *Specialists*, L.L.C.
360 S. Mt. Auburn Rd. • P.O. Box 2018 • Cape Girardeau, MO 63702-2018

SIGNATURE ON FILE FOR MEDICARE, MEDIGAP AND PRIVATE INSURANCE

Name of Patient: _____ **ID #** _____

Name of Medigap Insurer: _____ **Medicare Ins. Claim #** _____

Name of Private Insurer: _____

1. I request that payment of authorized Medicare benefits be made on my behalf to EYE CARE *Specialists*, LLC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

2. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from EYE CARE *Specialists*, LLC.

3. I request payment of authorized Private Insurance benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Private Insurance insurer any information needed to determine benefits payable for services from EYE CARE *Specialists*, LLC.

_____ _____

Signature of Patient or Legal Guardian *Date Signed*

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EYE CARE *Specialists*, L.L.C.

360 S. Mount Auburn Rd.
Cape Girardeau, MO 63703
573-335-3577 • 800-455-3937

64 Doctors' Park
Cape Girardeau, MO 63703
573-334-5265 • 800-333-1568

679 Physicians Park Dr.
Poplar Bluff, MO 63901
573-686-5579

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease

Patient Signature (or Representative)	*Date*	*Relationship to Patient (if other than patient)*

Witness: Printed Name of Practice Representative

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