Southern Retina
EYE SPECIALISTS

Date____/____/_____

Patient Name _____
First MI Last

Social Security Number_____-_____-_____ Date of Birth____/___/_____

Mailing Address _____

City_____ State_____ Zip _____

Home Address _____
(if different from mailing address)

City_____ State_____ Zip _____

Email Address_____ Cell Phone ( )_____-_____

Pharmacy: _____ Leave Message Yes ____ No _____

Home Phone ( ) -_____ Work Phone ( )_____- _____

Employer_____Occupation _____

Marital Status: (circle if yes) Single Married Divorced

Emergency Contact _____ _____ _____
name phone relationship

How did you hear about us? _____

Referred by _____ Phone ( ) - _____

Medical/Family Physician _____ Phone ( ) - _____

Notice to Patient:

By signing this form, you grant us consent to treat you and to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

It is your responsibility to pay any deductible amount, co-insurance, co-pay or other balance not paid for you by your insurance co. You are financially responsible for all charges, collection costs, attorney fees, and court costs on your account.

Eyeglass prescriptions are usually not paid for by insurance and a fee will be charged to you.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we might decline to treat you.

_____ _____/_____/_____
Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient