EMPIRE EYE AND LASER CENTER

PATIENT INFORMATION FORM

PERSONAL INFORMATION

Patient Name:_____Preferred Name:_____

SS#: _____DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Ph#: _____ Cell Ph#: _____ Work Ph#:_____

Email: _____

Preferred Phone#: ❑ Home ❑ Cell ❑ Work Preferred Contact Method: ❑ Text ❑ Email ❑ Phone

Race: _____

Ethnicity:_____

Preferred Pharmacy (include address): _____

Referring Physician:_____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

EMERGENCY CONTACT / SPOUSE / PARENT / RELATIVE INFORMATION

Name: _____ DOB: _____

Relationship to Patient: _____ Phone: _____

Employer: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____DOB: _____

ID #: _____ Group#: _____

Relationship to Subscriber: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____DOB: _____

ID #: _____ Group#: _____

Relationship to Subscriber: _____

I certify that the information on this form is correct to the best of my knowledge.

_____ _____

Patient Signature Date

*** PLEASE TURN PAGE OVER ***

EMPIRE EYE AND LASER CENTER

Patient Name: _____DOB:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Empire Eye and Laser Center. I hereby authorize said assignee to release all information necessary to secure payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges not paid by my insurance, including non-covered services—such as refraction and cosmetic procedures.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called Protected Health Information (PHI), under a federal health privacy law. I further understand that my PHI may be used to carry out treatment, payment, or healthcare operations.

I understand that I may revoke this authorization at any time by notifying Empire Eye and Laser Center in writing.

I have received a copy Empire Eye and Laser Center's **Notice of Privacy Practices** prior to signing this consent.

I understand I have the right to restrict how my PHI is used or disclosed by notifying Empire Eye and Laser Center of my wishes in writing.

PATIENT FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services.

I understand that I am responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by my insurance carrier, which are not otherwise covered by my primary or supplemental insurance.

_____ _____

Patient Signature Date