WACO EYE ASSOCIATES, P.A.

PATIENT INFORMATION

All services, when appropriate, are due and payable at the time of service.

First Name _____ M.I. _____ Last Name _____ SS# ____/____/____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Age _____ Marital Status _____ Sex Male / Female

Phone (____)_____ Cell Phone (____)_____ Email Address _____

Race Black-African American // Alaskan Native // American Indian // Asian // Native Hawaiian-Other Pacific Islander // White

Ethnicity Hispanic or Latin / Not Hispanic or Latino Language Preferred English / Spanish / Other

Employer _____ Work Phone (____)_____

Address _____ City _____ State _____ Zip _____

Guardian / Spouse _____ Date of Birth ____/____/____

SS# ____/____/____ Employer _____ Phone (____)_____

Emergency Contact _____ Phone (____)_____

Primary/Referring Physician _____ Phone (____)_____

Is this visit related to a Workers Comp Claim YES / NO Date of Injury ____/____/____

Please present your insurance cards to the receptionist

Prior Authorization (please initial each statement)

_____ I authorize release of any medical information necessary to process my claims to all my insurance companies.
_____ I authorize direct payment of medical benefits to Waco Eye Associates for services provided to me.
_____ I permit a copy of this authorization to be used in place of the original.
_____ I certify the above information is true and correct and realize that I am financially responsible for all medical bills.

Patient's Signature _____ Date _____

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy, The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. We also want you know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future times you may request to refuse all or part of your PHI. You may revoke actions that have already been taken which relied on this or a previously signed consent. You have the right to review our privacy notice, to restrictions and revoke consent in writing after you have reviewed our privacy notice.