

PATIENT INFORMATION

CHART #

FIRST NAME _____ LAST NAME _____ MI _____

PREFERRED NAME _____ DATE OF BIRTH _____ SSN # _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ - _____ CELL PHONE (_____) _____ - _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ TELEPHONE _____

PLEASE MAKE THE APPROPRIATE SELECTION NEXT TO EACH OF THE FOUR QUESTIONS BELOW:

Appointment Reminderpreference:

Text Message Phone Call

Race African American Asian Caucasian Latino Other

Ethnicity Hispanic Non-Hispanic

Gender Female Male

YOU WILL NEED TO FILL OUT YOUR INSURANCE INFORMATION BELOW.
ONCE YOU HAVE COMPLETED THIS FORM (FRONT & BACK) WE WILL NEED A COPY OF YOUR PHOTO ID AND INSURANCE CARD(S)
IF YOU DO NOT HAVE A PHYSICAL COPY OF YOUR CARD(S) AND YOU HAVE A DIGITAL COPY YOU CAN EMAIL IT TO
INFO@AUBURNEYEPHYSICIANS.COM - A PHOTO ID IS REQUIRED FOR ANY BILLING OF INSURANCE.

M E D I C A L INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE

SECONDARY MEDICAL INSURANCE

INSURANCE COMPANY _____ INSURANCE COMPANY _____

POLICY # _____ POLICY # _____

POLICY HOLDER _____ POLICY HOLDER _____

POLICY HOLDER DATE OF BIRTH _____ POLICY HOLDER DATE OF BIRTH _____

POLICY HOLDER PHONE # _____ POLICY HOLDER PHONE # _____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____

FINANCIALLY RESPONSIBLE- IF SOMEONE OTHER THAN THE PATIENT

FIRST NAME _____ LAST NAME _____ MI _____

DATE OF BIRTH _____ SSN # _____ RELATIONSHIP TO THE PATIENT _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ - _____ CELL PHONE (_____) _____ - _____

PLEASE TURN TO THE BACK OF THIS PAGE TO COMPLETE THE FORM → →

INSURANCE ASSIGNMENT AND CONSENT FOR TREATMENT CHART #

I HEREBY AUTHORIZE AUBURN EYE PHYSICIANS, PC 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 FURNISH TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE. I ALSO UNDERSTAND THAT IF MY ACCOUNT HAS TO BE REFERRED TO A COLLECTION AGENCY FOR COLLECTION OF THE DELINQUENT BALANCE, I WILL BE RESPONSIBLE FOR ALL COLLECTION FEES AND INTEREST COST INCURRED. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I FURTHER AUTHORIZE THE PHYSICIAN(S) AND STAFF OF AUBURN EYE PHYSICIANS, PC TO EXAMINE MY EYES AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH AN EYE EXAMINATION.

SIGNATURE (PATIENT OR PATIENT'S PARENT OR LEGAL GUARDIAN IF UNDER 18)

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 SIGNING THIS CONSENT.

I UNDERSTAND THAT THIS PRACTICE HAS THE RIGHT TO CHANGE THEIR PRIVACY PRACTICES AND THAT I MAY OBTAIN ANY REVISED NOTICES AT THE PRACTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST A RESTRICTION OF HOW MY PROTECTED HEALTH INFORMATION IS USED. I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, BY MAKING A REQUEST IN WRITING, EXCEPT FOR INFORMATION ALREADY USED OR DISCLOSED.

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

NAME _____

RELATIONSHIP _____

NAME _____

RELATIONSHIP _____

NAME _____

RELATIONSHIP _____

PRESCRIPTION INFORMATION

PLEASE CHECK ONE OF THE FOLLOWING BOXES

- 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 (PATIENT OR PATIENT'S PARENT OR LEGAL GUARDIAN IF UNDER 18)

DATE

RELATIONSHIP TO PATIENT (IF SIGNED BY SOMEONE OTHER THAN PATIENT)

REFRACTION CHARGE - PATIENT RESPONSIBILITY

I UNDERSTAND THAT MY INSURANCE MAY NOT COVER THE REFRACTION CHARGE AND I WILL BE RESPONSIBLE TO PAY THE \$25 CHARGE.

SIGNATURE (PATIENT OR PATIENT'S PARENT OR LEGAL GUARDIAN IF UNDER 18)

DATE

Chart # _____

Appointment Confirmation

- We will provide a reminder five days prior to your appointment via text message or phone call.
- I understand that I am required *to confirm my appointment* no later than 48 hours prior to my appointment.
- If I fail to do so my appointment will be cancelled.

No Show Fee & Cancellation Fee

- There will be a \$25 charge applied to your account if you no show your *confirmed* appointment or cancel without a 24-hour notice.

**** I am aware it is my responsibility to contact the office and provide any updated contact information so that I am able to successfully receive the appointment reminder ***

I have read the statements above and understand and agree to all policies.

Print Name

Signature

Today's Date