

PATIENT INFORMATION FORM

Dr. Mr. Mrs. Ms. Miss Date of Birth _____ Age _____

Legal Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Mobile Phone # _____

Social Security # _____ E-mail address _____

Employer _____ Work Phone # _____ Occupation _____

Spouse's Name _____ Spouse's Phone # _____

Family physician _____ Phone # _____

REASON FOR CONSULTING OUR PRACTICE

Doctor Referral (Name) _____ Address _____

Family/Friend (Name) _____ ER/Urgent Care _____

Columbus Yellow Pages Delaware County Yellow Pages Insurance

PERSON RESPONSIBLE FOR BILL (Other than yourself)

Legal Name _____ Relationship _____
First MI Last

Address _____ City _____ State _____ Zip _____

VISION COVERAGE: VSP EYEMED SELF-PAY COMPEYECARD

PRIMARY INSURANCE INFORMATION

Plan Name _____

Policy Holder's Name _____ Relationship Self Spouse

Policy Holder's Social Security # _____ Policy Holder's Date of Birth _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name _____ Phone # _____ Relationship _____



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*Affiliated with
The Eye Center of Columbus*



FINANCIAL POLICY

By my signature below, I indicate that I understand that I am ultimately responsible for payment of my bill. CECCO will send my claim to the insurance company that I presented at the time of the visit and will accept assignment on the plans that they are participating with. CECCO will send a claim, upon request, on my behalf, to insurances they are not participating with; I am however responsible for the full payment of the bill.
Co-pays and deductibles are also due at the time of service.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits and/or payment from my current insurance carrier/ supplemental insurance be made on my behalf to Comprehensive EyeCare of Central OH, Inc for any services furnished to me. I further authorize the release of pertinent information needed to determine these benefits or the benefits payable for related services, to the Health Care Financing Administration and/or my insurance carrier/supplemental insurance carrier and its agents.

Release of Information

Practice Philosophy on Patient Privacy

The Practice recognizes the importance of patient privacy. As such it is the policy of this Practice to treat all medical information as confidential and absent extraordinary or emergency circumstances, the Practice will not disclose a patient's medical information without appropriate patient consent.

Before consenting to the release of medical information, each patient has the right to review the written Notice of Privacy of this Practice, which gives a more complete description of the Practice's policies on the use and disclosure of patients' medical information. Each patient may obtain a copy of such Notice upon request. The Practice reserves the right to change its Notice of Privacy Policy and all patients have the right to receive an amended copy of the Notice upon request.

Also, each patient has the right to request in writing that this Practice restrict how protected and private information is used or disclosed to carry out treatment, payment, or other health care operations. Please note that this Practice is not required to agree to such requested restrictions, but if it does, the restriction will be binding upon the Practice. Additionally, the Practice may refuse to treat any patient who refuses to consent to the use and disclosure of medical information for treatment, payment, or other health care operations purposes.

Patient Consent for Use and Disclosure of Medical Information for Payment or Treatment Purposes

I, as the patient, or authorized representative of the patient, consent to the release of information regarding services rendered by the Practice to my insurance company or any governmental payor of the medical expenses as listed above, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of medical information to my family physician and other treating physicians, as listed by me above, as well as to any physicians to whom the Practice may refer me for purposes of further treatment. I consent to the use and/or release of medical information about me for purposes of health care operations, including quality assurance activities or other activities to review the Practice's treatment and services and to evaluate the performance of staff in caring for me. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person (s) that I have listed above as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail ("email") and facsimile.

I further **consent** **do not consent** to the discussion of my medical condition/treatment options either in the presence of a family member/relative or over the phone with a family member/relative as long as relationship is established.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has taken action in reliance upon my consent.

Patient/Parent/Guardian Signature: _____ **Date:** _____