PLEASE FILL OUT ENTIRE FORM
(PLEASE PRINT CLEARLY)

Strom Eye Center

Date: ____________________

Name: Mr/Miss/Mrs ___________________________________

Your Spouse or Parent: _________________________ Email Address: ____________________________

Guarantor (Responsible Party): ____

Address: ________________________________Apt#: _____ City: ____________ State: _____ Zip: ________

Summer Address: ___________________________________ City: ____________ State: _____ Zip: ________

Date of Birth: ________________________ Social Security #: _____________________________________

Telephone: Home: ___________________ Cell #:___________________Business: _____________________

Referred by: ______________________________ Employed by: ___________________________________

Emergency Contact Person: ________________________ Phone #: _____________________

Medicare Number: ______________________________

Is Medicare your primary insurance? ☐ yes ☐ no

◆◆

Other Insurance: **THIS INFORMATION MUST BE PROVIDED FOR INSURANCE BILLING**

Name of Insurance Company: ________________________________

Billing address: ____

____

Policyholder information:

Policyholder: _____________________________ Relationship to patient: ___________________________

Employer/Company:___________________________________Active______Retired__________________

Policy No: ________________________________ Group No: ____________________________________

Policyholder Date of Birth: ______________________ Policyholder SS #: ___________________________

LIFETIME AUTHORIZATION

I request that payment of authorized health insurance benefits be made either to me on my behalf or to the Strom Eye Center for any services furnished me by any doctor who is associated with the Strom Eye Center.

I authorize any holder of medical or other information about me to release to my health care plan, HCFA, or any of their agents any information needed to determine these benefits for related services.

I acknowledge that a copy of Notice of Privacy Practices, as amended January 25, 2013 describing how health information will be used or disclosed is available to me upon request.

Signature: **Date:**

____

(Patient, Parent or Legal Guardian)

____

(*Printed name if not signed by Patient) (*Relationship/Authority to Act on behalf of the patient)

*If not signed by the patient you must provide Strom Eye Center with a copy of the document of authority that makes you the patient’s personal representative (i.e. Health Care Power of Attorney, Health Care Surrogate, Health Care Proxy, Guardian, etc.). We will also need a copy of your driver’s license.

Strom Eye Center

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name:_____Date of Birth:_____

Please CHECK one of the following:

☐ I give my permission to the employees of Strom Eye Center to disclose my Protected Health Information to me **AND** the following friends or family:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

OR

☐ I request that all my Protected Health Information be disclosed **ONLY** to me and no other friends or family.

I understand that I may revoke or change this authorization at anytime by filling out another 'Consent to Disclose Medical Information' form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that the information used or disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by Federal and State privacy laws. I understand that I have a right to receive a copy of this authorization if I request one. I also understand that this authorization will not expire.

Signature: **Date:**

(Patient, Parent or Legal Guardian)

(*Printed name if not signed by Patient) (*Relationship/Authority to Act on behalf of the patient)

*If not signed by the patient you must provide Strom Eye Center with a copy of the document of authority that makes you the patient's personal representative (i.e. Health Care Power of Attorney, Health Care Surrogate, Health Care Proxy, Guardian, etc.). We will also need a copy of your driver's license.