THE CENTER FOR SIGHT, P.A.

General Patient Information

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How did you hear about our office? *(please select one.)*

☐ Billboard ☐ Newspaper ☐ Yellow Pages
☐ Radio ☐ Walk-In Patient ☐ Health Fair Screening
☐ Doctor: _____ ☐ Family Member/Friend: _____ ☐ Other: _____

Name: _____ (Last) _____ (First) _____ (Middle) **Age:** _____ **Sex: M F**

Address: _____ (Street Address/P.O. Box) _____ (City) _____ (State) _____ (Zip)

Telephone Numbers: _____ _____ _____
How may we reach you best? *Check One:* ☐ Home ☐ Work ☐ Cellular

Social Security #: _____ **Date of Birth:** _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other _____

Place of Employment: _____ **Phone:** _____
☐ Part Time ☐ Full Time

Spouse/Parent (If Minor): _____ **Employer:** _____

Person Responsible for Payment: _____ **Phone:** _____
(Other Than Insurance)

IN CASE OF EMERGENCY, WHOM DO WE NOTIFY?

Name: _____ Relationship: _____ Phone: _____

INSURANCE COVERAGE

(Please show your insurance card(s) and photo I.D. to the receptionist)

☐ ***No insurance (private pay)***	
INSURANCE INFORMATION (PRIMARY)	*INSURANCE INFORMATION (SECONDARY)*
Name of Insurance:	Name of Insurance:
Name of Policy Holder:	Name of Policy Holder:
Policy Holder Employer: DOB: SSN:	Policy Holder Employer: DOB: SSN:
Primary Care Physician (PCP)	Primary Care Physician (PCP)
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other	Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Acknowledgment of Review of Notice of Privacy Practices

I have had an opportunity to review this office's Notice of Privacy Practices, which explains how my Medical Information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I understand that, in routine medical situations, The Center For Sight will not release any of my Protected Health Information (PHI) to my family, care giver, or friend(s) without the expressed written consent from me, the patient, power of attorney, or in the case of a minor, parent/legal guardian. I only give consent to release information from this medical record to the specified individual(s) as designated by me.

Please choose one of the following two options; then sign and date below.

☐ **Yes**, my protected health information may be released to the following person(s):
(Examples may include Spouse or other Family Member, Friend, etc.)

The Center for Sight may release my information to:	Relationship to Patient:
_____	_____
_____	_____

☐ **No**, do not release my protected health information to anyone.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date

ASSIGNMENT OF BENEFITS: I consent to the release of any medical information necessary to process insurance claims, and authorize payment for medical benefits to my physician. I accept responsibility for any balance that may not be paid by insurance.

PAYMENT IS EXPECTED AT TIME OF SERVICE: I understand that payment in full is expected at time of service, unless prior arrangements have been made. I also understand that payments will not be delayed because of insurance coverage unless arrangements are made at time of service and that all proceeds of insurance are assigned to this office. I further understand that Medicare assignments are accepted in this office, but Medicare deductibles, refraction fees and co-payments are due at the time of service.

CONSENT TO TREATMENT: I consent to treatment provided by The Center For Sight that my doctor recommends to treat my condition, which may be in the form of examination, testing and medications. This treatment may include, but is not limited to scheduling procedures or appointments with another facility, calling in a prescription to a pharmacist or optician, or consulting with another provider.

CONSENT FOR MINORS: The following individual(s) may make treatment decisions for this minor.
This will remain in effect until written notice is provided for change.

Name:	Relationship:
_____	_____
_____	_____

SURGERY/LASER PATIENTS: I understand that the surgical fee for my procedure includes the procedure itself and 90 days of post-operative care related to the procedure (10 days for minor surgery). If I require additional care and/or an office visit that is not related to the surgical procedure, appropriate charges will be made. Following this “global period,” regular office fees will apply. In the event that a referral to another doctor, hospital and/or clinic is needed, this care will not be covered by the surgical fee.

METHODS OF CORRESPONDENCE: I understand that The Center For Sight may contact me by phone or by mail for healthcare treatment activity, such as verifying a scheduled appointment, assisting me with insurance, contacting me with a medical concern, or for reporting test results.

I, the undersigned patient or patient’s parent/legal guardian/power of attorney, have read the above information, or had it read to me, and I understand the information.

_____	_____	_____
☐ Signature of Patient ☐ Representative	Relationship to Patient	Date

Please Print Patient’s Name: _____