MID-ATLANTIC Eye Physicians

Patient Information

Please Print Clearly

Name: _____
(First, Middle Initial, Last)

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

Mailing Address: _____ **Sex:** □ Male □ Female

City: _____**State** _____**Zip** _____

Physical Address: _____
□ Same As above (Street, City, Zip)

Home phone: (_____)-_____-_____ **Cell phone:** (_____)-_____-_____ **Alter phone:** (_____)-_____-_____

Email Address: _____ **Preferred Method of Contact:**

Type	Ok to Leave Message
□ Home Phone	□
□ Cell Phone	□
□ Alternate Phone	□
□ Email	□

Employer Name: _____

Local Medical Doctor Name: _____ Phone: (_____)-_____-_____

Marital Status: □ Single □ Married **Ethnicity:** □ Hispanic/Latino □ Non Hispanic/Latino **Preferred Language:** □ English □ Other_____(specify)

Race: □ Amer. Indian/Alaska Native □ Asian □ Black/African-Amer. □ Native Hawaiian/Other Pacific Islander □ White □ Other

Insurance Policy Holder: □ Self □ Spouse □ Parent/Guardian □ Other_____(specify)

Name: _____**Date of Birth:** _____ **Sex:** □ Male □ Female

Please Check that you have read each of these statements that you are agreeing to:

- □ I authorize Mid-Atlantic Eye Physicians to **RELEASE MEDICAL INFORMATION** necessary to process my insurance claims. I also **AUTHORIZE PAYMENT** of medical and/or surgical benefits to Mid-Atlantic Eye Physicians for services provided.
- □ I authorize Mid-Atlantic Eye Physicians to **RELEASE MY OPHTHALMOLOGICAL RECORDS** to my referring doctor and/or local medical doctor.
- □ I acknowledge that I have received a copy of Mid-Atlantic Eye Physicians' **NOTICE OF PRIVACY OF PRACTICES**. This assignment shall be valid until revoked.
- □ I agree to meet my **FINANCIAL RESPONSIBILITY** by making full payment at the time of service, for all services rendered unless covered by my insurance company. Full payment is also expected at the time of service if I am covered by an out of network insurance. All co-payments and deductibles are expected to be paid in full at the time of service. I will be paying today's visit by □ **Check** □ **Cash** □ **Credit Card**
- □ I have read and understand the information concerning the **REFRACTION TEST**.

Signature_____ **Date** ____/_____/_____

HOW DID YOU HEAR ABOUT US?

Our patients are important to us. By providing the following information, you will allow us to personally thank your referral source. **PLEASE CHECK THE APPROPRIATE LINE:**

□ Optometrist _____
Name of OD

□ Medical Doctor _____
Name of MD

□ Patient _____
Name of referring Patient

□ Newspaper □ RR Daily Herald □ Lake Gaston Gazette □ Littleton Observer
□ South Hill Enterprise □ Chase City News Progress

□ Yellow Pages □ Roanoke Rapids □ Tri-County □ Rocky Mount □ Ahoskie
□ Lake Book □ Buggs Island □South Hill □ Nottoway

□ Radio □ WZRU □ WPTM □ WLGQ

□ Internet

□ Other (Please Specify): _____

PLEASE HAVE YOUR INSURANCE CARDS AVAIALBLE AT CHECK IN, THANKS!

MID-ATLANTIC Eye Physicians

Authorization for Release of PHI

Name of Patient _____ Date of Birth _____

Mid Atlantic Eye Physicians is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Other (provide name and phone number) _____ _____ (relationship)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification
☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication,	

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and this will not affect my treatment.

Signature_____ Date ____/_____/_____