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** ____/_____/_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications with Patients and their Families, Friends, or Caregivers

This form authorizes Mid Atlantic Eye Physicians (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and a trusted family member, friend, or caregiver. This form is optional and does not expire.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Primary Contact Number:** (___) _____ ☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may orally communicate to the family members, friends, or caregivers listed below. Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

Name: _____ Phone: (___) _____

Name: _____ Phone: (___) _____

Name: _____ Phone: (___) _____

☐ This practice may **NOT** communicate with my family members, friends, or caregivers.

ACKNOWLEDGEMENT AND SIGNATURE

- You acknowledge that information related to a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse might be included in a communication you authorize on this form. Information that has been shared as permitted by this form may be redisclosed and no longer protected by state or federal privacy laws.
- You can revoke or stop the communications on this form at any time in writing. It will not apply to any communications that were made before our practice received your written notice to stop the communications.
- An Authorization to Release Health Information or Patient Access Request must be completed for this practice to provide copies of or transmit your health information/records to anyone other than you.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

_____ _____

Patient/Personal Representative Signature Date

Description of Personal Representative's Authority (attach necessary documentation if not previously provided)

_____