Brainerd Eye Care Center

"Caring for the Health of Your Eyes"

Patient Information: (Please Print)

Legal Name: _____ Nick Name: _____ ___Male ___Female
First MI Last

DOB:_____ Address _____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____ SS # _____

E-Mail Address _____ If Married, Name of Spouse _____

If Child, Father's Name_____ Address _____ Phone _____

Mother's Name _____ Address _____ Phone _____

Responsible Party:

Name of Person Responsible For This Account _____ Relationship To Patient_____

Address _____ Home Phone_____ Cell Phone_____

*Other family members who should be linked to this account: _____

_____

Insurance Information: (Please present all insurance cards)

Medical Ins. #1 _____ Name of Insured _____ DOB: _____ SS #_____

Insured Address _____ Insured ID # _____ Relationship to Patient _____

Medical Ins. #2 _____ Name of Insured _____ DOB: _____ SS #_____

Insured Address _____ Insured ID # _____ Relationship to Patient _____

Vision Insurance _____ Name of Insured _____ DOB: _____ SS #_____

Insured Address _____ Insured ID # _____ Relationship to Patient _____

If This Is Your First Visit, Whom May We Thank For Your Referral? _____

Are You Interested In Contact Lenses?_____ Sunglasses?_____ Refractive Surgery?_____

SIGNATURE ON FILE

I hereby authorize the release of any information by Brainerd Eyecare Center to my insurance company, Medicare, or pre-paid health plan on behalf of myself and/or dependents. I request that payment of all authorized insurance benefits be made either to me or on my behalf to Brainerd Eyecare Center for services furnished to me or my dependents, by any of the optometrists/opticians of Brainerd Eyecare Center. I authorize any holder of medical information about me, or my dependents, to release to the required insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for paying for any deductibles, co-payments, non-covered items, or spend down amounts not covered by my insurance. I permit a copy of this authorization to be used in place of the original. This signature will remain in effect until revoked by me in writing.

Date _____ **Patient Signature (Or Guarantor if minor or unable to sign)** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Brainerd Eyecare Center
506 Laurel Street
Brainerd, MN 56401
218-829-0946

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

SIGNATURE

I,_____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____