Battleground eyecare Dr. Jon Scott

Patient Information and Agreement Form

Patient Information

Date: _____ **[ ] Female** **[ ] Male** **Race**:_____

Patient's Full Name: _____

Address: _____

Home Phone:_____ Work #: _____ Cell#: _____

[ ] Married **[ ] Domestic Partner** **[ ] Single** **[ ] Divorced** **[ ] Widowed** **[ ] Separated**

Social Security# (needed to file insurance): _____ Drivers License # (if paying by check)_____

Date of Birth: _____ **E-mail Address**: _____
(please provide - used for correspondence from our office – reminders, newsletters, etc)

Occupation _____ Employer _____

Spouse's Full Name: _____

Spouse's Social Security Number (if Primary Member)_____ Spouse's Phone: _____

If patient is a minor, give parent or guardian's name: _____

Person to contact in case of emergency: _____ Phone: _____

How were you referred to our office? (circle one) Insurance Listing Phonebook Drive-by Internet Search School nurse

Another Patient: _____ Another Doctor: _____

Responsible Party Information (if different from above)

Full Name :_____

Address:_____

Home Phone: _____ Work / Cell#: _____

Social Security# (needed to file insurance): _____ Date of Birth_____

Relationship to Patient: _____

Occupation _____ Employer _____

NAME OF **VISION** INSURANCE: _____

PRIMARY **MEDICAL** INSURANCE: _____

SECONDARY INSURANCE: _____

I understand that I am responsible for payment in full when services are rendered. I authorize my insurance benefits to be paid directly to Battleground Eye Care, OD, PA, realizing I am responsible to pay all non-covered charges and co-payments. If prior authorization or referral authorization is necessary, it is my responsibility to obtain it. I further authorize release of any medical records to my insurance company which are necessary to process my claim. Some insurance companies are now charging a higher co-pay based on diagnosis. If my insurance company charges a higher co-pay than what was collected at my visit, for whatever reason, I will be responsible for the difference. Late payments accrue interest at one and one-half percentage (1 1/2%) per month from invoice date if payment is not made within 25 days of the billing date. Should collections be required, I agree to pay reasonable attorneys' fees and all reasonable expenses incurred by you in collecting monies owed.

You Must Sign Here
To Be Seen By Doctor →

_____
PATIENT SIGNATURE (PARENT OR GUARDIAN OF CHILD)

HIPAA* Acknowledgement Form:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the **Battleground Eye Care Privacy Officer** at **(336) 282-2273 or by visiting www.battlegroundeye.com/privacy.htm**

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

I understand that my healthcare information may not be shared with anyone, however I authorize the following individuals unrestricted access to my records:

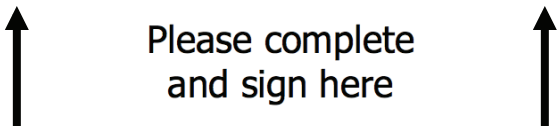
1) Name: _____ Relation_____

2) Name: _____ Relation_____

3) Name: _____ Relation_____

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

PATIENT'S NAME (PRINT):	PATIENT'S (OR GUARDIAN'S) SIGNATURE:	DATE:



* Health Insurance Portability and Accountability Act

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We are required to ask these questions. Please answer to the best of your ability.

- **What is your preferred language?** Please check one

  ___ English
  ___ Other - Please List: _____

- **Ethnicity:**

  Are you of Hispanic or Latino origin or descent?

  ___ Yes, Hispanic or Latino
  ___ No, not Hispanic or Latino

- **What is your race?** Please check one or more.

  ___ White
  ___ Black or African-American
  ___ Hispanic/Latino
  ___ Asian
  ___ Native Hawaiian or other Pacific Islander
  ___ American Indian or Alaska Native
  ___ Other

- **What is your Height** _____ ft _____ inches**, Weight** _____ lbs