WELCOME!

PLEASE COMPLETE THIS INFORMATION FORM BY FILLING OUT THE THREE PARTS IN BLACK INK

Part 1 PATIENT INFORMATION

Patient Name ______________________________________

Address ____

____
City State Zip

Home Phone____

Cell Phone____

Work Phone____

Email Address______________________________________

Sex ☐ M ☐ F Birthday ______________________

Social Security Number _____________________________

Occupation ____

Employer ____

Employer Address ___________________________________

Employer Phone _____________________________________

Spouse's Name ______________________________________

Birthdate __________________ SS# ___________________

Occupation ____

Spouse's Employer___________________________________

How did you first hear about Tarr Family Eyecare?

☐ Referred by friend or relative. Who? _______________________

☐ Referred by health care provider. Who? _____________________

☐ Referred by Insurance. Which? ______________________________

☐ Office Signage or Billboard. Which? ________________________

☐ Newspaper Ad ☐ Radio Ad ☐ Direct Mail

☐ Community Event or Civic Group. Which? ____________________

☐ Other ____

Part 2 INSURANCE

Who is responsible for this account? ___________________

Relationship to Patient _________________________________

Birthdate __________________ SS# ___________________

Insurance Company ______________________________________

ID Number ____

Is patient covered by additional insurance? ☐ Y ☐ N

Subscriber Name ____

Birthdate __________________ SS# ___________________

Relationship to Patient _________________________________

Insurance Company ______________________________________

ID Number ____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance companies listed above and assign directly to Tarr Family Eyecare all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I have read and understand the posted financial policy. I authorize the use of this signature on all insurance submissions.

* ____________________________________ _______________
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to Tarr Family Eyecare for services furnished me by Tarr Family Eyecare. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form**, or elsewhere on other approved claim forms or electronically submitted claims, **my signature authorizes releasing of the information to the insurer or agency shown**. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

* ____________________________________ _______________
Beneficiary Signature Date

Part 3 CONSENT FOR USE OR DISCLOSURES OF HEALTH INFORMATION

We are concerned about protecting your privacy. While the law requires us to give you this disclosure, rest assured that we have and always will respect the privacy of your personal health information. There are several circumstances in which we may have to use or disclose your health care information.

-- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
-- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
-- We may need to use your health information within our practice for quality control or other operational purposes.
-- We have a more complete notice that provided a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (45 CFR § 164.520). We reserve the right to change our privacy practices as described in that notice.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. I have read your consent policy and agree to its terms. I am also acknowledging that I have read a copy of this notice.

APPOINTMENT REMINDERS AUTHORIZATION: Your optometrist & staff may need to use your name, address, phone number, & your clinical records to contact you with appointment reminders, info about treatment alternatives, or other health related info that may be of interest to you. If this contact is made by phone & you are not at home or at work, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders & info.

* ____ _______________
Beneficiary Signature Date

TARR
FAMILY EYECARE