WESTSIDE EYE CENTER PATIENT INFORMATION

PATIENT NAME_____ GENDER_____

RESPONSIBLE PARTY IF MINOR:_____

EMPLOYER_____

ADDRESS _____ CELL#_____

CITY/STATE/ZIP _____ HOME#_____

DOB_____ SS# XXX-XX-_____ E-MAIL:_____

ETHNICITY_____ RACE_____
Insurance companies require we ask you this. You may decline to answer.

EMERGENCY CONTACT:_____ PH#_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand and acknowledge that Westside Eye Center will keep records of my eye care services provided at this clinic. I may ask for a copy of that record. I understand that my information will not be disclosed to others unless I direct Westside to do so or unless the law authorizes them to do so.

My signature below acknowledges the "Notice of Privacy Practices" information as described.

Signature of responsible party_____ Date_____

The "Notice of Privacy Practices" handout (available upon request) describes in more detail how your health information may be used and disclosed.

MEDICAL AND/OR FINANCIAL INFORMATION CAN BE SHARED UPON REQUEST.

I, _____, give permission for Westside Eye Center to share medical/financial information with the following:

NAME_____ Circle information to share: MEDICAL/FINANCIAL

NAME_____ Circle information to share: MEDICAL/FINANCIAL

FINANCIAL RESPONSIBILITY

I authorize Westside Eye Center to provide my insurance company with medical care information and services rendered as required to substantiate payment.

I understand that I am financially responsible for my health insurance deductible, co insurance or non-covered services.

Signature of Responsible Party_____ Date_____

Please complete the back side of this form.