Patient Information (Please print clearly)

Name: First _____MI. ___ Last _____
Preferred Name/Nickname (if different than above): _____
Age ____ Date of Birth _____/_____/_____ Sex _____
Address _____
City_____State _____ Zip Code _____
Mailing Address (if different) _____
City_____State _____ Zip Code _____
Home Phone (_____) _____ Work (____) _____ Cell (____) _____
Social Security No. _____ E-mail _____
Employer _____Occupation _____
Marital Status (please check one) Single___ Married___ Divorced___ Widowed ____
Spouse's Name _____
Parents' Names (if dependent) _____
Other Contact _____ Phone _____
Medical Doctor _____Phone _____
Pharmacy _____ Phone _____

Primary Language _____

Race: (Please check one)
__Black or African American __Asian ___American Indian or Alaska Native ___White
Native Hawaiian or Other Pacific Islander ___Other ___ Decline to Answer

Ethnicity: (Please check one)
___Non-Hispanic or Latino ___Hispanic or Latino __Unknown___Decline to Answer

By signing below, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor/s to examine, diagnose, and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment.

_____

Patient/Parent or Guardian Today's Date

Insurance Information
Name of **Medical** Insurance _____
Primary Member's Date of Birth _____Primary Member's SS# _____
Name of **Vision** Insurance _____ Primary Member's Date of Birth _____Primary Member's SS# _____

Statement of Financial Policy
Our office is doing everything possible to keep the cost of your eye care down. In order to do this, we ask that the payment be made when services are rendered. A deposit is required prior to ordering any materials. The balance is due on delivery.

Insurance Authorization
I request that payment of benefits be made to Sweetwater Family Eyecare. I authorize any holder of medical information about me to release the information needed to determine the benefits payable. Certain routine services and/or materials that are necessary to assess for good vision or eye health may not be covered by my insurance. I will be expected to pay for those services and/or materials in full if denied by insurance. I also agree to pay any remaining balance after my insurance has been applied where applicable. Should my account become delinquent and require the services of a collection agency or an attorney, I will pay reasonable collection fees, attorney fees, and all court costs for collection. I have read the above policies and agree as indicated by my signature.

_____

Patient/Parent or Guardian Today's Date

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will respect the privacy of your 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 services.
- We may need to use your health information within our practice for quality control or other operational purposes.

The above examples fall into the categories of treatment, payment, and health care operations. By law, we are not required to have your specific consent to use your information when it falls within these categories. However, this form establishes your consent to use your information within these categories without specific notice to you. We have a more complete notice that provides 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 as dictated by federal law (45 CFR 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

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 organization. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of the Notice of Privacy Practices from Sweetwater Family Eyecare, PLLC or was offered a copy and declined it.

_____

Patient Name (printed) Date

_____

Patient or Personal Representative Signature

_____

Personal Representative (printed) Relationship of Personal Representative to Patient

Sweetwater Family Eyecare, PLLC
689 A New Hwy 68
Sweetwater, TN, 37874-41911
423-337-9222

Authorization to Release Health Information to Specific Individuals

I have listed below individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time but must do so in writing. I also understand that Sweetwater Family Eyecare will not be able to honor my revocation request with respect to any information released prior to receiving the request to revoke authorization. This authorization is valid for three (3) years from the date listed below, unless revoked or renewed prior to that date.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth