Solinsky EyeCare
Ophthalmology Optometry Contacts Glasses & Hearing

PATIENT INFORMATION

PLEASE PRINT INFORMATION

PATIENT'S NAME		S.S. #	DATE OF BIRTH	☐ MALE ☐ FEMALE
MAILING ADDRESS		CITY, STATE & ZIP	HOME EMAIL ADDRESS	
HOME PHONE	CELL PHONE	PREFERRED PHONE (circle one) CELL HOME	MAY A DETAILED MESSAGE BE LEFT ON YOUR PREFERRED PHONE? (circle one) YES NO	
EMPLOYER NAME AND ADDRESS		WORK PHONE	MARITAL STATUS *(circle one)* S M W D	
RESPONSIBLE PARTY IF OTHER THAN SELF		RELATIONSHIP TO RESPONSIBLE		
EMERGENCY CONTACT/ RELATIONSHIP		EMERGENCY CONTACT NUMBERS		
FAMILY PHYSICIAN NAME, ADDRESS, PHONE NUMBER				
NAME OF REFERRING PHYSICIAN OR OPTOMETRIST		ADDRESS OF REFERRING PROVIDER		
NAME OF PREFERRED PHARMACY		ADDRESS OF PREFERRED PHARMACY		

ACKNOWLEDGEMENT, AUTHORIZATION, AND CONSENT

Authorization for Examination and Treatment:
I hereby authorize the examination and/or treatment considered necessary for me and the treatment and procedures will be performed by the providers of Solinsky EyeCare, LLC. I understand that no guarantee or assurance has been made as to the results that may be obtained.

Assignment of Benefits:
I hereby assign and authorize my insurance carrier or other benefits plan including Medicare, other government sponsored insurances and benefits of which I may be covered and/or all commercial payors to make payments on my behalf directly to Solinsky EyeCare, LLC. I authorize Solinsky EyeCare, LLC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I also assign any Medigap benefits to be paid directly to my provider. If my insurance or benefits plan will not direct payment to Solinsky EyeCare, LLC, I agree to forward to Solinsky EyeCare, LLC all benefit payments which I receive for the services rendered by Solinsky EyeCare, LLC and its health care providers. I permit a copy of this authorization to be used in place of the original.

Financial Responsibility:
I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. I understand that all charges for services rendered at Solinsky EyeCare, LLC are ultimately the responsibility of the patient. Solinsky EyeCare, LLC will file claims with most insurance and benefit plans, however, once the claim has been processed, all co-insurance, copay, and deductible amounts as well as fees for any service rendered not covered by my insurance policy are due upon receipt of the billing statement. You will receive a statement from Solinsky EyeCare, LLC for such fees not collected at the time of service. I further agree that, if permissible by law, I will reimburse Solinsky EyeCare, LLC for all costs, expenses and attorney's fees that may be incurred in attempts to collect those charges.

Authorization to Release Information:
I hereby authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself or child/children for services. I also authorize any holder of medical information about me to be released to the Health Care Financing Administration upon their request.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____ _____

Patient/Person Legally Responsible ***Relationship to Patient*** ***Date***

PLEASE COMPLETE BOTH SIDES

COMMUNICATION AND PRIVACY ACKNOWLEDGEMENT

PATIENT NAME	DATE

FAMILY & FRIENDS:

It is the policy of Solinsky EyeCare, LLC not to release confidential medical information regarding your treatment to family members or friends except for parent/legal guardian, other persons authorized by the patient, as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, in emergency situations, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below. By signing below, you authorize the following people to receive information regarding your treatment or care: (If you wish to add names later on, please confirm this in writing).

ALTERNATIVE COMMUNICATIONS

The policy of Solinsky EyeCare, LLC is to communicate with you through the following means: Mail, to the listed home address; telephone through your preferred listed phone (text messages for appointment reminders if a cell phone is listed); and secure email if an email address is listed. You may request other reasonable alternate communication means. Please request alternative communication means in the appropriate section below.

NAME / RELATIONSHIP	PHONE NUMBER
NAME / RELATIONSHIP	PHONE NUMBER

ALTERNATIVE COMMUNICATION REQUESTED (circle one)	COMMUNICATION METHOD REQUESTED
YES ***NO***	

Patient Name (Printed)

Patient/Guardian Signature | Relationship if other than patient | Date

PHARMACY INFORMATION RELEASE

In order to provide high quality and more efficient care, Solinsky EyeCare, LLC can obtain your medication information from your pharmacy. This information can be critical to providing safe and effective care. By signing below you authorize the release of your medication records from your pharmacy.

Patient Name (Printed)

Patient/Guardian Signature | Relationship if other than patient | Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at Solinsky EyeCare, LLC (Practice). These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer." The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I may see and copy the information described in this form and if I request, a copy of this form after I sign it. I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: • Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); • Obtaining payment from third party payers (e.g. my insurance company); • The day-to-day healthcare operations of your practice such as quality assessments.

I have also been informed of and given the right to review and a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA

Patient Name (Printed)

Patient/Guardian Signature | Relationship if other than patient | Date