

DeCarlo Eye Center

PATIENT INFORMATION

ACCOUNT#

Name:	Date of Birth:
Address:	Social Security #:
City:	Sex:
State: Zip:	Marital Status:
Primary Phone#:	Emergency Contact:
Cell Phone#:	Emergency Phone#:
Primary Care Doctor:	Emergency Relationship:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member ID#:	Member ID#:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Relationship to Patient:	Relationship to Patient:

Release of Information/Benefits Authorization: I authorize release of any medical information necessary to process insurance claims. I further authorize payment directly to Dr. DeCarlo/DeCarlo Eye Center for any and all insurance claims filed on my behalf.

Responsibility for Payment: I agree to pay any fees charged by Dr. DeCarlo/DeCarlo Eye Center for services rendered that are not covered by my insurance company, including coinsurance, copays and deductibles. I further agree that if this account becomes delinquent I will pay any collection costs, including court and attorney fees if applicable.

X _____

PATIENT OR GUARDIAN SIGNATURE

DATE

Privacy Notice/HIPAA Authorization

I acknowledge that Dr. DeCarlo/DeCarlo Eye Center has offered me a copy of its Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. This acknowledgement will remain in effect until I so choose to revoke it in writing.

I understand that Dr. DeCarlo/DeCarlo Eye Center will not discuss protected health information without authorization.

I authorize the Dr. DeCarlo/DeCarlo Eye Center to release my protected health information to the following people:

X _____

PATIENT OR GUARDIAN SIGNATURE

DATE

