PATIENT INFORMATION – WOLFEBORO EYE ASSOCIATES

Last Name

First Name MI

Nickname

Mailing Address

City

State Zip

Home Phone ( )

Daytime Phone ( )

Cell Phone ( )

E-mail

Preferred Contact Method:

Sex ○ Male ○ Female

Date of Birth / / Age:

Social Security # - -

Marital Status: ○ M ○ S ○ D ○ W

Race/Ethnicity:

Employment Status:

○ Full Time ○ Part-Time ○ Retired

○ Self-Employed ○ Student ○ Other

Insurance Subscriber

Subscriber's D.O.B.

Relationship to Insured:

Who may we thank for referring you?

Privacy and Confidentiality Acknowledgement: I understand that Wolfeboro Eye Associates (WEA) will disclose only the minimal amount of my healthcare information that is necessary, in the judgment of WEA, for the legitimate needs of the recipient or for my own well-being. This includes health care information, written or not, about the preventive, diagnostic, or treatment services provided to me and/or that may be used to identify me. This authorization to disclose will remain in effect for all subsequent disclosures of health care information for the limited purposes outlined above for thirty (30) months from this authorization unless I revoke it. I understand that I may refuse to disclose some or all health care information and that I may revoke this authorization at any time by providing WEA with a written, signed, and dated request. However, I understand that my refusal to disclose some or all health care information may result in incorrect diagnosis and/or treatment, denial of a claim for health benefits or other insurance, or other adverse consequences.

Wolfeboro Eye Associates and their employees and agents regard the safeguarding of your confidential health care information as an important duty. The elements of this authorization are required by state and federal law for your protection and to insure your informed consent to the disclosure of health care information necessary to support your relationship with Wolfeboro Eye Associates.

Please ask the office staff or your doctor if you have any questions about our policies. Thank you.

I authorize Wolfeboro Eye Associates, Inc. to submit claims to my health insurance carrier and to release any medical information necessary to process all claims. I authorize payment of medical benefits to the named provider – Wolfeboro Eye Associates, Inc. – for professional services rendered.

- **I authorize** the release of medical information necessary to process my insurance claims _____ **(Initials)**
- **I authorize** the release of any insurance information and diagnosis codes to any co-management facilities used for my care _____ **(Initials)**

Do you wish to receive a detailed copy of our HIPAA Privacy Practices? ○ **Yes** ○ **No**

Patient or Legal Guardian Signature **Today's Date:**

Please read and complete the Patient Financial Policy on reverse