Patient Information Update

Eye Associates Group, LLC - Low Vision Centers of Indiana

Date _____

Patient's Name (First, MI, Last) _____ Social Security #_____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Marital Status (circle one) S M W D

Patient's Employer _____ Work Phone_____

Employer Address _____ City_____ State_____ Zip _____

School Name, if student _____ City _____

If Married: Spouse's Name _____Spouse's Employer _____

If Minor: Father's Name _____ Father's Employer _____ City _____

Father's Social Security # _____ Father's Date of Birth _____

Mother's Name _____ Mother's Employer_____ City _____

Mother's Social Security # _____ Mother's Date of Birth _____

Name of closest relative or friend that does not live with you_____

Relationship to Patient_____ Phone #_____

Have you ever been examined by our doctors? Yes / No Which Doctor? _____

How did you hear about our office/who referred you? _____

Are you a resident of a Skilled Nursing Facility? (circle one) Yes No

If Yes, Name & Address of Facility_____

INSURANCE (Please complete all information even if a copy of your insurance card(s) was provided)

Primary *Medical* Insurance_____ Insured ID#_____

Insured's Name _____ Insured's Date of Birth _____

Relationship to Patient_____ Employer_____

Secondary *Medical* Insurance _____ Insured ID#_____

Insured's Name _____ Insured's Date of Birth _____

Relationship to Patient_____ Employer_____

Primary *Vision* Insurance_____ Secondary *Vision* Insurance_____

Insured's Name_____ Insured's Name_____

Insured's Date of Birth_____ Insured's Date of Birth_____

Email: Please enter your email here if you would like us to be able to contact you by email with information on vision and eye health or to reach you if we are unable to contact you by telephone. We do not share your email with any outside entities.

Print Email Address _____

Please turn over and complete the other side of this form.

Account Responsibility, Signature on File, Assignment of Benefits & Financial Agreement

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf to Eye Associates Group, LLC for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. My signature authorizes releasing the information to the insurer or agency shown. I further authorize releasing information to all insurances companies including Medigap policies. Eye Associates Group, LLC/Low Vision Centers may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation 1) which is or may be liable or under contract to for reimbursement for services rendered, and 2) any health care provider for continued patient care. I understand that I am responsible for any and all charges that are not paid for by my insurance company. This authorization remains in effect until withdrawn by me.

Signature_____ Date _____

HIPAA Privacy Notification and Authorizations

To comply with the HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your spouse, children, family members, caregivers, friends, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn by you at any time.

Name_____ Relationship_____
Phone _____

Name _____ Relationship_____
Phone_____

By signing below, I acknowledge that I have received HIPAA notification and authorize the Eye Associates Group, LLC/Low Vision Centers to share information with any persons listed above.

Signature _____ Date _____

Form Revised 3/12/09