Moses EyeCare Centers  **Moseseyecare.com**

PLEASE FILL THIS FORM OUT COMPLETELY

Today's Date: _____

Patient Name: *First* _____ *MI* _____ *Last* _____ Marital Status: S M W D

Gender: Male ____ Female____ Date of Birth: _____ Social Security Number _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Employer: _____ Occupation: _____

Are you online? We use a website called Demandforce to communicate with our patients via text and email. This website also provides a survey to let us know how your visit was.

Can we get a hold of you via email? □ Yes □ No Email Address: _____

Can we get a hold of you via text? □ Yes □ No

RESPONSIBLE PARTY / MAIN INSURED / GUARDIAN

□Please check box if ***all*** of responsible party information is the same as patient information above

Name: _____ Date of Birth: _____ Social Security Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____Whom may we thank for referring you? _____

I authorize this office to release any information necessary to expedite processing insurance claims. I understand and agree I am personally responsible for all charges, regardless of insurance coverage for services and materials provided by Moses EyeCare Centers. Insurance charges unpaid within sixty (60) days following the date of service will transferred to the responsible party or patient. I understand and accept responsibility for service charges, late fees, and other costs, including attorney fees incurred in the collection of this account.

X _____ **OR** **X** _____

Patient Signature Parent of Guardian (Responsible Party)

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change is *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X _____ **OR** **X** _____

Patient Signature Parent of Guardian (Responsible Party)