

******Patient Information******

Last Name _____ First Name: _____ Male ___ Female ___

Street Address _____ Apt _____ P.O. Box _____

City _____ State _____ Zip _____ Date of Birth _____

Social Security # _____ Marital Status Single Married Divorced Widowed Partner

Home Phone # () _____ - _____ Work Phone # () _____ - _____ ext. _____ Cell Phone# _____

E-Mail Address _____ May we email you? Yes No **Student** **Full Time** **Part Time**

******Primary Care Physician / Full Name of Dr. _____**

******Medical Insurance Information**** Primary Subscriber's Information**

Primary Insurance: _____ Subscriber _____ Relation to subscriber _____

Employer _____ SSN# _____ Date of Birth _____

Secondary Subscriber's Information

Secondary Insurance _____ Subscriber _____ Relation to subscriber _____

Employer _____ SSN# _____ Date of Birth _____

I understand I am responsible for providing HARTFORD EYE PHYSICIANS, P.C. with a copy of my current insurance card and a referral if required by the insurance plan. Failure to do so will result in a claim denial, and I will assume full financial responsibility.

“I authorize the release of any medical or other information to the CMS and its Agents, in order to process the claim. I also request payment of government benefits and/or other Insurance Company benefits to either myself or the party who accepts assignment.”

******SIGNATURE: _____ DATE: _____**

******NOTICE OF PRIVACY PRACTICES *****THIS MUST BE FILLED OUT**

You will have the right to read our posted Notice of Private Practices before you decide whether to sign this Consent. Our Notice provides a description, payment activities, and health care operations of the uses and disclosure we may make of your protected health information. I had full opportunity to read and consider the contents of this Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

******SIGNATURE: _____ DATE: _____**

*****If personal representative on behalf if the patient signs this consent, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

I wish to have the following individual (s) allowed access to my protected health information:

(Example: family members, friends not Dr.'s)

1. _____ Phone Number _____

2. _____ Phone Number _____

I do not wish to allow access to my protected health information (Example:Spouse, Family Member, etc.)

Date: _____ **Hartford Eye Physicians, P.C.** Acct # _____