bweye

New Patient Paperwork

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____Secondary Phone Number: _____

*Email Address: _____Gender: _____ Marital Status: _____

Emergency Contact Name: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Responsible Party, if child: _____

Address (if different from the above): _____

Employer: _____ Employer Address: _____

Who may we thank for referring you to our practice? _____

Insurance Information:

Primary Insurance Name: _____Address: _____

Police Holder Name: _____ Date of Birth: _____

Member Id: _____Group Number: _____

Secondary Insurance Name: _____Address: _____

Police Holder Name: _____ Date of Birth: _____

Member Id: _____Group Number: _____

Clinic Appointment Policy:

In the interest of our patients, if you missed your appointment or have to cancel/reschedule your appointment we ask that you please notify our office prior to 24 hours before your visit. If you are unable to do so, a **$35 APPOINTMENT FEE** will be charged.

Your timely Notification of your need to cancel/reschedule will help us be more available to provide care to others on the day your appointment was scheduled to occur. We appreciate your help and understanding.

Signature: _____ Date: _____

Medical Life Time Signature on File: I authorize payment of Medicare Benefits to the BWEye center for services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration to determine benefits.

Signature: _____Date: _____

FINANCIAL AGREEMENT: I authorize payment of any insurance benefits for unpaid services to the BWEye Center and I am responsible for any balances after insurance claims have been paid. If co-payments and/ or deductibles are designated by my insurance provided by the BWEye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the BWEye Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

Signature: _____Date: _____

BALTIMORE WASHINGTON EYE CENTER

PATIENT CONSENT FORM

The Baltimore Washington Eye Center's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed for treatment or payment of health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to use and disclose protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. The Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- BWEye has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- BWEye reserves the right the change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the Center does not have to agree to those restrictions.
- The patient may evoke the Consent in writing at any time and all future disclosures will then cease.
- BWEye may condition treatment upon the execution of this Consent.

This Consent was signed by (**Patient Name Printed**) _____

(**Patient Signature**) _____

_____ (Also has permission to receive PHI for this patient)

Designated person to whom info may be shared (Relationship to Patient) _____

In front of _____ (BWEye Representative) Date: _____