Today's Date: _____

PATIENT INFORMATION

EDINA EYE
A DIVISION OF TWIN CITIES EYE CONSULTANTS

Patient Name: _____ Date of Birth ____/____/____
First MI Last

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

****Which phone number is best to leave messages and reminders? ❑ Home ❑ Cell**

Social Security No. ____-____-____ Sex: M/ F Marital Status: Single / Married / Widowed / Divorced

E-mail Address: _____

Employer's Name: _____ Occupation/Position: _____

Employer's Address: _____
Street City State Zip

Pharmacy Name: _____
Name City State Phone

Referring Physician: _____
Name Address

Primary Physician: _____
Name Address

Emergency Contact: _____
Name Phone Relationship

How did you hear about us: ____TV ____Internet ____Physician ____Relative ____Insurance ____Friend
____Other_____

Primary Language: English____ Spanish____ Arabic____ Cantonese____ Hebrew____ Japanese____ Korean
Mandarin____ Russian____ Decline to answer____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____ Decline to answer_____

Race: American Indian/Alaska Native____ Asian____ Black/African American____ White____
Native Hawaiian/Pacific Islander____ Other____ Decline to answer____

INSURANCE

Primary Insurance Company: _____ Subscriber Name: _____
Subscribers Date of Birth: ____/____/____

Secondary Insurance Company: _____ Subscriber Name: _____
Subscribers Date of Birth: ____/____/____

Separate Vision Insurance Plan: VSP Cigna Metlife None Subscriber Name: _____
Subscribers DOB: ____/____/____ Last 4 digits of Subscribers SS#: ____-____-____

Person Responsible for payment, if not patient: _____
Relationship to patient: _____ Social Security Number: ____-____-____
Address: _____ City, State, Zip: _____
Daytime phone: _____

EDINA EYE
A DIVISION OF TWIN CITIES EYE CONSULTANTS

Account No. _____

Patient Name: _____ Date of Birth: ____/____/____
First MI Last

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I acknowledge that I have received your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and 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 out treatment payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

SIGNATURE OF PATIENT OR AUTHORIZED PARTY: X_____ DATE: _____

Authorized Party if other than patient: _____
Print Name

Relationship: _____ Daytime phone number: _____

Staff use only:

The Patient or Authorized Party noted above was provided the Notice of Privacy Practices and this Acknowledgement Form and did not sign the Acknowledgement Form.

Reason for not signing: _____

Name: _____ Date: _____

Position: _____

MEDICAL/FINANCIAL DISCLOSURE

Dear Patient,

In order to protect your privacy and be in compliance with the new laws regarding patient privacy, we need your signature on this form to disclose medical/financial information to any person other than yourself. If you do not sign this form, we will not divulge any medical/financial information about you to anyone other than your insurance company.

NAME	RELATIONSHIP TO YOU	PHONE

SIGNATURE OF PATIENT: X_____ DATE: _____

SIGNATURE OF WITNESS: _____ DATE: _____

Account No. _____

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name (Print) **Medicare Number (if applicable)**

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Edina Eye, for services furnished me by Edina Eye. 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 benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Edina Eye accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Edina Eye, if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** Edina Eye 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 Edina Eye for reimbursement for services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE:** I understand that Edina Eye maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Edina Eye has no contract, expressed or implied with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Edina Eye if I belong to a plan that does not appear on the above mentioned list.
5. **NON-COVERED SERVICES:** I understand that Edina Eye contact with health care service plans (i.e. HMOs, PPOs) state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Edina Eye to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Edina Eye, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to collection expenses and reasonable attorney's 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. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient, is hereby assigned to Edina Eye. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Edina Eye. **However, it is understood that the undersigned and /or the patient are primarily responsible of the payment of my bill.**

Patient Signature or Authorized Party **Date**