BRUNSWICK EYE CARE ASSOCIATES
Patient Information

Full Name:		Date:	
Email Address:		Social Security #:	
Birth Date:	Sex: (circle): M / F / NB / OTHER	Birth Gender (circle one): M / F	Preferred Pronoun:
Street Address:			
City:	State:	Zip Code:	
Home phone #	Cell Phone #	Work Phone #:	
Name of Emergency Contact:		Phone #:	
Relationship to patient:			
Primary Care Physician:		Phone #:	
Primary Insurance:			
Secondary Insurance:			

RESPONSIBLE/INSURED PARTY INFORMATION (IF DIFFERENT FROM PATIENT AND/OR PATIENT UNDER 18 YEARS OLD)		
Name:		Birth Date:
Street Address:		City:
State	Zip Code:	Phone:
Social Security #:	Employer:	

IF PARENTS ARE DIVORCED THE PARENT BRINGING THE CHILD TO THE OFFICE IS RESPONSIBLE FOR ALL BILLS.

INSURANCE INFORMATION

Please present all insurance cards and payment information to the receptionist. It is the patients responsibility to provide current insurance information; failure to do so may result in patient being responsible for balances.

It is the patients responsibility to adhere to their insurance policy in regards to network and referrals, failure to do so may result in patient being responsible for balances.

We are not in network with any vision plans.

FINANCIAL / MEDICAL RELEASE INFORMATION

I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby give authorization for payment of insurance benefits to be made directly to Brunswick Eye Care Associates. In the event of default, I agree to pay all cost of collection and reasonable attorneys fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and agree that a photocopy of this agreement shall be as valid as the original.

INITIAL:

HIPAA CONSENT

We have a comprehensive Notice of Privacy Practices that describles how we create, receive and store health information that identifies you. When you sign this consent you signify that you are aware of or have asked for and received a copy of our Notice of Privacy Practices. You also signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. We can decline to serve you if you elect not to sign this form.

Signature:	**Date:**

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient:	Printed Name:
Source of Authority:	