EUGENE EYE CARE

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Matthew Neale, MD
Eye Physician & Surgeon
Diplomate, American Board of Ophthalmology

Steven Ofner, MD
Eye Physician & Surgeon
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Darrin P Fleming, OD
Optometric Physician

Dianna Bordewick, MD
Eye Physician & Surgeon
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PATIENT REGISTRATION

If you have glasses and/or contact lenses please bring them to your appointment. Previous prescription is acceptable.

Name (as shown on insurance card): _____
First MI Last

Address: _____
Street or P.O. Box City State Zip

Primary Phone: (___) _____ Secondary Phone: (___) _____ Email: _____

Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birthdate: _____ Age: _____ Social Security #: _____

Patient's Occupation: _____ Employer: _____ Work #: (___) _____

Referred by Doctor: _____ Primary Care Physician _____

Emergency Contact: _____ Relationship: _____ Contact#: (___) _____

Responsible Party (The person who is responsible for the bill after the insurance has been paid)

☐ Self ☐ Other Person (If responsible party is other than patient, please fill out lower section)

Name: _____ Relationship: _____ Contact #: (___) _____

Address: _____
Street or P.O. Box City State Zip

Birthdate: _____ Age: _____ Social Security #: _____

Occupation: _____ Employer: _____ Work #: (___) _____

Primary Insurance: (To ensure proper billing please provide information requested below)

Policy Holder's Name: _____ Birthdate: _____

Insurance Company: _____ ID Number: _____

Relationship to patient: _____ Social Security #: _____

Secondary Insurance: (To ensure proper billing please provide information requested below)

Policy Holder's Name: _____ Birthdate: _____ ID Number: _____

Relationship to patient: _____ Social Security #: _____

Please bring your insurance cards to your appointment.

Continue ⇨

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change and you may obtain a revised copy by contacting our office. Your signature on the bottom of this page affirms that you understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that you have the opportunity to review this notice.
- The Practice has a right to change the Notice of Privacy Policies
- You may revoke this Consent in writing at any time.

PERMISSION TO DISCLOSE HEALTH INFORMATION

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare, but only if you agree we may do so. Please list the individuals below who have your permission to share healthcare information.

Name	Relationship to Patient	Any Restrictions?

When necessary, I authorize release of **all personal health information** to the any listed recipient ***except*** the following information: (Initial all that apply)

_____ Mental Health

_____ Alcohol/Drug abuse treatment

_____ Communicable diseases (including HIV and AIDS)

_____ Other (please specify): _____

_____ **Initial here if you acknowledge the following statement: It is my understanding that without vision coverage through my insurance there will be an out of pocket cost of $44 for a refraction. I also understand a refraction is what allows me to receive my glasses and/or contact lens prescription. (This applies to all Medicare plans).**

I hereby authorize Eugene Eye Care Associates to furnish to my insurance company, employer, their representatives, or referring party any necessary information concerning my examination or treatment. I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished during the effective period of this authorization. I also request payment of government benefits either to myself or to the party who accepts assignment. My signature also gives my consent regarding the Notice of Privacy Practices listed above which complies with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: _____ Date: _____