West Georgia Eye Care Center

THE FOLLOWING INFORMATION IS CONFIDENTIAL HEALTH INFO AND WILL NOT BE SHARED

Full Name: _____ Date of Birth: _____

Street Address: _____ Age: _____

City, State, Zip: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Guardian: _____ Relation to Patient: _____

Family Doctor Full Name: _____

Primary Insurance: _____ Policy #: _____

Primary Insured/Subscriber: _____ DOB: _____

Subscriber's Gender: _____ Male Female _____

Secondary Insurance: _____ Policy#: _____

How did you hear about us: (Circle One)

Were you referred to WGECC by a doctor? If so, which doctor referred you? _____

Patient Referral Internet Radio Yellow Pages Billboard Newspaper TV

Family/Friend: _____ Other: _____

I authorize WGECC and/or any doctor associated with this practice to furnish information to insurance carriers regarding my illness and treatment. I hereby assign to the practice all payments for medical services rendered to me or dependents.

I understand that all copayments (specialist co-pay may be more than primary care co-pay) and/or deductibles and/or non-covered services not covered by my insurance are my responsibility and are required to be paid at the time services are rendered. In the event of non-payment, referral to a collection agency may be required. Insufficient funds checks will be charge an additional $25 NSF fee.

REFRACTION is the measurement determining the prescription for glasses or contact lenses. Medicare and other insurance DO NOT COVER refractions. Separate vision care insurance may cover or discount refraction, but generally our physicians DO NOT PARTICIPATE in vision care plans, and you are responsible to pay for the refraction, usually $30 or less.

Signature: _____ Date: _____

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AUTHORIZED PATIENT NOTIFICATION LIST
HIPPA PRIVACY PRACTICES ACKNOWLEDGEMENT FORM
Required by HIPPA (Health Insurance and Portability and Accountability)

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I authorize WEST GEORGIA EYE CARE Doctors and staff designated by the doctor as representative to discuss any aspect of my care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people:

_____ _____

_____ _____

_____ _____

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. This form supersedes any previous versions.

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices and have been provided an opportunity to review the same.

_____ Date: _____

Patient or authorized person

_____

Relation to above