Office Use Only (HIPAA-9/12/02)

***Appt Date*_____ *Time*_____*Dr*_____*Office*_____ ☐ Packet Sent To Pt.

***Requested By*_____*Location*_____ *Dr Phone*_____

Name_____ Sex M F

Address _____

City _____State_____ Zip_____

Home Phone_____ Cell/Work Phone_____

Marital Status _____ SSN _____ Date of Birth _____

Employer_____ Circle if applicable: Disabled Retired Unemployed

Pharmacy Name _____Pharmacy Location _____

Primary Care Doctor_____ Doctor Phone_____

Doctor Address_____ City_____ Zip_____

Additional Doctors (Specify) _____

Emergency Contact _____Relationship_____

Emergency Contact Phone_____

Insurance Information (Please give <u>Picture ID and Insurance cards</u> to the receptionist)

*Primary I*nsurance_____ *Secondary* Insurance_____

Medical Group _____ Auth # (if needed) _____

Authorization for: **FA/FP** **TREATMENT** **CONSULT** **OTHER**_____

I give my permission for Bay Area Retina Associates to communicate information regarding my health, care and progress to the individual(s) listed here:

1._____ Relationship_____

2._____ Relationship_____

☐ I decline to designate a specific individual to have information about my health, care and progress.

Signature_____ Date_____

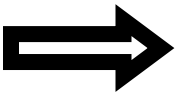
I give my permission for Bay Area Retina Associates to leave a message on my answering machine.

Signature_____Date_____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Bay Area Retina Associates, and any assisting physicians, for services rendered. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature_____ Date_____

Is anyone other than you responsible for Insurance payment?
Please complete reverse side of this form!



Patient/Responsible Party Information

Responsible Party Name _____

Date of Birth_____ SSN_____

Relationship to Patient (Circle): Self Spouse Parent/Guardian Other_____

Home Phone_____ Work Phone_____

Home Address_____

City_____State_____Zip_____

Employer_____

Employer Address_____

City_____State_____Zip_____

Occupation_____