Karl M. Larsen O.D.

WELCOME TO OUR OFFICE

Today's Date:_____ ***(Please Note : If patient is under the age of 18 Parent or Guardian Information Section MUST be filled out.)***

Patient's Last Name _____ First Name _____

Birth Date _____/_____/_____ Age _____ Male/Female _____SS#_____

Home Phone #_____Work Phone #_____Cell Phone #_____

Street Address _____

City _____ State _____ Zip Code _____

Are other family members treated here? Y _____ N _____ If so, Who? _____

Whom may we thank for referring you to our office? _____

EMPLOYMENT INFORMATION

Employer_____ Occupation_____

Employer Address_____

PARENT OR GUARDIAN INFORMATION

Name_____

Birth Date_____

Employer _____

Occupation _____

Home Phone _____

Cell Phone _____

Work Phone _____

SPOUSE INFORMATION

Name_____

Birth Date_____

Employer _____

Occupation _____

Home Phone _____

Cell Phone _____

Work Phone _____

INSURANCE INFORMATION

Primary Insurance

Name of Insurance Co _____

Name of Insured _____

SS# _____

Member ID _____

Birth Date of Insured _____

Relationship to Insured _____

2nd Insurance

Name of Insurance Co _____

Name of Insured _____

SS# _____

Member ID _____

Birth Date of Insured _____

Relationship to Insured _____

3rd Insurance

Name of Insurance Co _____

Name of Insured _____

SS# _____

Member ID _____

Birth Date of Insured _____

Relationship to Insured _____

4th Insurance

Name of Insurance Co _____

Name of Insured _____

SS# _____

Member ID _____

Birth Date of Insured _____

Relationship to Insured _____

INSURANCE DISCLAIMER

Your insurance will be billed by our office as a courtesy. Please understand that we do not have control over the coverage you have selected nor when your insurance will pay. Although we accept assignment from many insurance carriers, please remember that **YOU** are responsible for the balance on your account. We allow 90 days from the date of billing for payment from your insurance carrier. If your insurance does not pay within this time frame, then we ask you the patient to make arrangements to pay the outstanding balance on your account.

- I authorize release of information to all my insurance companies.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original
- I understand my medical records are confidential.
- I understand that by signing this consent form, I am allowing my medical information to be released upon request of my insurance.

Signature _____ Date _____

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you 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 healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from PROFESSIONAL EYECARE CENTER.

Signature_____**Date**_____

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

Relationship to Patient_____ **Print Name**_____

Source of Authority:_____

UPDATE FOR RETURNING PATIENTS

I have reviewed and acknowledge that my personal, employment, and insurance information has not changed or I have made the changes.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____