

PARKWAY OPTICAL
PATIENT INFORMATION FORM

PERSONAL INFORMATION

Patient Name: _____ Preferred Name: _____

SS#: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Ph#: _____ Cell Ph#: _____ Work Ph#: _____

Email: _____

Preferred Phone#: Home Cell Work Preferred Contact Method: Text Email Phone

Race: _____

Ethnicity: _____

Preferred Pharmacy (include address): _____

Referring Physician: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

EMERGENCY CONTACT / SPOUSE / PARENT / RELATIVE INFORMATION

Name: _____ DOB: _____

Relationship to Patient: _____ Phone: _____

Employer: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____ DOB: _____

ID #: _____ Group#: _____

Relationship to Subscriber: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____ DOB: _____

ID #: _____ Group#: _____

Relationship to Subscriber: _____

I certify that the information on this form is correct to the best of my knowledge.

Patient Signature

Date

PARKWAY OPTICAL

Patient Name: _____ DOB: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Parkway Optical/Empire Eye and Laser Center. I hereby authorize said assignee to release all information necessary to secure payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges not paid by my insurance, including non-covered services—such as refraction and cosmetic procedures.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called Protected Health Information (PHI), under a federal health privacy law. I further understand that my PHI may be used to carry out treatment, payment, or healthcare operations.

I understand that I may revoke this authorization at any time by notifying Parkway Optical/Empire Eye and Laser Center in writing.

I have received a copy Parkway Optical/Empire Eye and Laser Center's **Notice of Privacy Practices** prior to signing this consent.

I understand I have the right to restrict how my PHI is used or disclosed by notifying Parkway Optical/Empire Eye and Laser Center of my wishes in writing.

PATIENT FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services.

I understand that I am responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by my insurance carrier, which are not otherwise covered by my primary or supplemental insurance.

PATIENT OPT-IN

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. By requesting a ride, I also consent to be contacted on my phone number on file (including by autodialer) about my trip.

Patient Signature

Date