New Patient Information Form
Seymour Eye Clinic

The following information will assist the doctors in your examination.

Last Name: _____First:_____MI_____ Date:_____

Address:_____

City:_____ State:_____Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Email:_____

Birth Date:_____ SS#:_____

Employer: _____ Address: _____If student, grade & school:_____

Have any other members of your family been seen in this office? Yes_____ No _____

If yes, Who?

_____

Spouse's Name:_____ Birthdate:_____ SS#:_____

Employer:_____ Employer's Phone #:_____

If dependent, name of parent or guardian: _____

In case of emergency, notify:_____Relationship:_____Phone:_____

Person responsible for account:

_____

Do you have vision insurance that may cover part of our service? Yes _____ No _____

If Yes, Insurance Company: _____ Member ID::_____

I understand and agree that, although I may have vision insurance covering part or all of charges for services rendered, in the event any portion of my charges remain due and payable, I am responsible for paying that balance. I further understand and agree that, in the event my account becomes delinquent, I assume all responsibility for all collection agency fees charged, attorney fees, court costs and other costs incurred while collecting the amount due.

Signature:_____ Date:_____

You may use our secure direct address of Morgan.Luckey@direct.revolutionehr.com to submit electronic records from your health care provider's patient portal.

Seymour Eye Clinic
J. Michael Frische, O.D.
Noah Wahl, O.D.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patients Name: _____

Parent/Legal Guardian Name:_____

Signature:_____ Date: _____

Relationship to Patient: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- Other (Please specify)_____