

Welcome To Our Office

In the course of providing service to your, 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.

Mr. Miss Mrs. Ms. Male Female

 First Name MI Last Name Preferred Name

 Street Address City State Zip

 Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

 Email Address Guardian Person Responsible for Account

 Emergency Contact Emergency Phone

How were you referred to our office?

Who were you referred by?

- Phone Book School Advertisement Patient
 Insurance Listing Drive by Other Doctor

PRIMARY INSURANCE INFORMATION

 Name and Address of Primary Insurance Company City State Zip

M F

 Insured's First Name MI Insured's Last Name

 Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Patient Status

- Self Spouse Child Other

- Single Married Other

- Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

 Name and Address of Secondary Insurance Company City State Zip

M F

 Insured's First Name MI Insured's Last Name

Patient Relationship to Insured

- _____
 Insured's Identification Number Group Number Insured's Date of Birth Self Spouse Child Other

Please Read:

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 health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care 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 consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations.

I acknowledge that I have received and/or read the *Notice of Privacy Practices* form Empire Vision.

 Signature

 Date