Eye Consultants of Atlanta, P.C.

PATIENT

PATIENT'S NAME:_____ DATE OF BIRTH:____/____/____

ADDRESS:_____

CITY:_____ STATE: _____ ZIP:_____

HOME PHONE: (____)_____ WORK PHONE: (____)_____

SOCIAL SECURITY NUMBER: _____

SEX: M ❑ F ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑

FULL-TIME ❑ STUDENT PART-TIME ❑ STUDENT

OCCUPATION: _____ EMPLOYED BY: _____

CELL PHONE: _____

GUARANTOR

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT:
(0) SELF _____ (1) SPOUSE _____ (2) CHILD _____ (3) OTHER _____

HOME ADDRESS:_____

_____

EMPLOYED BY:_____

S.S.# _____ SEX: M ❑ F ❑ DATE OF BIRTH:____/____/____

HOME PHONE: (____)_____ WORK PHONE: (____)_____

E-MAIL ADDRESS: _____

NAME OF EMERGENCY CONTACT **NOT** LIVING WITH YOU: _____

RELATIONSHIP: _____ TEL. DAY: (____)_____ EVE.: (____)_____

IF CHILD, NAME OF PARENT OR GUARDIAN LIVING WITH CHILD: _____

ADDRESS:_____ PHONE: (____)_____

Your signature below authorizes us to release information and receive payment from your insurance company for those services received from the physician and the assisting physician.

SIGNED: _____ DATE:_____/_____/_____

_____ _____

REFERRED BY: PHYSICIAN'S NAME PRIMARY CARE PHYSICIAN'S NAME

This Authorization Remains in Effect Unless Revoked by me in Writing:

1.) I hereby authorize EYE CONSULTANTS OF ATLANTA, P.C., hereinafter referred to as "ECA", to provide information concerning any treatment rendered to me, or to any member of my family, to:
   a.) my insurance carrier(s)
   b.) any physician who referred me to "ECA"
   c.) any medical practitioner "ECA" physicians may refer me (them) to for further medical or therapy treatment.

2.) I authorize the release of any medical information, including confidential information related to psychiatric care, drug and alcohol use, and HIV/AIDS treatments, necessary to process insurance claims or required for utilization, review, or quality assurance activities.

3.) I further authorize "ECA" to utilize any modern form of transferring this documentation - including, but not limited to: the U.S. Mail, Federal Express, telefacsimile (faxes), couriers or other similar methods - to its requested destination.

4.) I hereby assign to "ECA" all applicable payments to be received from my insurance carrier(s) for medical services rendered.

5.) I hereby agree that *I am personally responsible* for ensuring that all the charges for services rendered are paid by either myself or my insurance carrier(s).

☞ X _____ _____
Patient's Signature (Parent or Guardian, if minor) Relationship to Patient

PATIENT'S UNDER 18 YEARS OF AGE
MUST BE ACCOMPANIED BY A PARENT OR GUARDIAN.

THIS IS REQUIRED BY LAW AND SERVES TO PROTECT YOU AND YOUR CHILD.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to "ECA" for any service furnished to me by those physicians. I authorize any holder of medical information to release to the Health Care Financing Administration, i.e., Medicare, and its agents, any information needed to determine those benefits or the benefits payable for related services.

☞ X _____ _____ _____
Patient's Signature Medicare Number Date of Signature

Notice of Privacy Practices Acknowledgement

Eye Consultants of Atlanta P.C.

Patient Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting **Richard A. Rodecker, Ph.D., FACMPE** at **(404) 351-2220 extension 1270**.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient's Name (Print):	Patient's Signature:	Date:

Requests for Confidential Communication of Protected Health Information

Patient Name In Full (Please Print) Today's Date

Address: Street, City, State, ZIP

Birth Date	Social Security Number Home Number	Work Number

I, _____, request that ***Eye Consultants of Atlanta P.C.*** communicate with me, or the designated individual(s) identified below, concerning my medical information by the following method:

Designated Person(s):

Alternative communications method example: answering machine, pager, email, and anyone who accompanies me in the exam room.

Patient – Signature	Date	Time

Person Authorized To Sign For Patient: Relationship to Patient:

This authorization shall remain valid until _____, 200__, or until the expiration of one year from the date executed herein, whichever occurs first. I understand that I have the right to revoke this authorization at any time.

ECA
Eye Consultants of Atlanta
Committed to Excellence in Total Eye Care

LIST OF ALL MEDICATIONS

MEDICATIONS THAT ARE TAKEN EVERY DAY BY MOUTH/INJECTION:

ALL EYE DROPS THAT ARE PUT INTO YOUR EYES:

ALLERGIES:
