145 Myrtle St. Ste. 108 Sutherlin, OR 97479 541-459-4333 phone 541-459-7512 fax

RESPONSIBLE PARTY for the patient

Relationship to patient: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law

Name: ______________________ Responsible Party's Phone ______________

Mailing Address ____
Box/street City State Zip

Employer ______________________ Work Phone ______________________

Social Security Number: ______________________ Date of Birth ______________

PRIMARY INSURANCE for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law

Policy Holder's Name ____
First Middle Int. Last

Insurance Name ______________________ Group Name/Employer ______________

Group # ______________ *Policy ID#* ______________ *Effective Date* ________

Policy Holder's Date of Birth ______________ Policy Holder's SS# ______________

COMPLETE NAME OF FAMILY MEMBERS ON PLAN

Name: ______________________________ DOB: ______________

Name: ______________________________ DOB: ______________

Name: ______________________________ DOB: ______________

Name: ______________________________ DOB: ______________

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Palm Family Eyecare to render needed treatment to the above named patient.
2. I authorize Palm Family Eyecare to release information regarding my treatment to my insurance company for billing purposes.
3. I authorize payment of benefits to Palm Family Eyecare for services rendered.
4. I understand that I am responsible for all charges incurred through Palm Family Eyecare.
5. **Authorization Period (circle one): One Year / Until 18 years of age / Lifetime**

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect Collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees, court costs and collection fees of $75.00.

Signature ______________________________ Date ______________

Signature ______________________________ Date ______________

ACKNOWLEDGMENT AND CONSENT

I understand that Palm Family Eyecare, referred to below as ("This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

1) make decisions about and plan for my care and treatment;
2) refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
3) determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
4) perform various office, administrative and business functions that suport my physician's efforts

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I shall receive a copy of the Notice of Privacy Practices upon request.

By: ______________________________ Date: ____________________

Patient

By: ______________________________ Date: ____________________

Patient Representative

Description of Representative's Authority: