Bittel Vision Care

PATIENT INFORMATION

Patient Name: _____ Marital Status: _____
Social Security Number: _____ Driver's License Number: _____
Employer: _____ Employer's Phone Number: _____
Employer's Address: _____

Emergency Contact: _____
Phone Number: _____ Relationship: _____

Guarantor Information (Person Responsible for Payment of Account)
Guarantor Name**:** _____ Guarantor's Phone: _____
Guarantor's Address: _____ Relationship to Patient: _____
_____

Insurance Information

Primary Vision Insurance
Name of Insurance: _____
ID # _____
Name of Policy Holder: _____ Relationship to Patient_____
Policy Holder D.O.B.:_____ Employer: _____

Other Vision Insurance
Name of Insurance: _____
ID # _____
Name of Policy Holder: _____ Relationship to Patient_____
Policy Holder D.O.B.:_____ Employer: _____

Primary Medical
Name of Insurance: _____
ID # _____ Group #_____
Name of Policy Holder: _____ Relationship to Patient_____
Policy Holder D.O.B.:_____ Employer: _____

Secondary Medical
Name of Insurance: _____
ID # _____ Group #_____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder D.O.B.:_____ Employer: _____

Worker's Compensation/ Auto Accident/ Trauma (Circle and Complete on Reverse Side)

Assignment of Benefits: I hereby assign all medical and/or vision benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Bittel Vision Care. This agreement 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 whether or not paid by insurance. I am financially responsible for the deductible, co-insurance, and non-covered services. Copays and non-covered services are to be paid at the time services are rendered. I have read and understand the payment policy of Bittel Vision Care.

Signed by Patient or Guarantor: _____Date:_____

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Accident Claim Information

Date of Accident: _____

Type of Accident (Circle One): Worker's Compensation / Automobile / Other

Claim Number: _____

Insured Party: _____

Name of Insurance Company: _____

Claim Address: _____

Phone: _____

Name of Claim Representative: _____

CONSENT TO USE OF DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing service to you, 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.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of claims to your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our web site.

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. We can decline to serve you if you elect not to sign this consent form.

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 obligated 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 PURPOSES OF TREATMENT, AND HEALTH CARE OPERATIONS.

Date: _____ Patient Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form: Relationship to Patient _____ Print Name _____

Source of Authority _____

Questions or complaints: Contact persons – Karen or Meghan (Office Managers) 412-884-2020