Patient Information Form

*Please **print** all information in the spaces provided. Be sure to complete and sign the statement on the bottom of this form.*

Last Name_____ FirstName_____ M.I._____
Home
Address_____
Home Phone_____ Work Phone_____
Employer Name and Address_____
Social Security Number_____ Date of Birth_____
Primary Medical Insurance
Company Name and Phone Number_____
Billing Address_____
Name of Insured and Relation to Patient_____
Insured's ID Number_____ Group Number_____
Vision Plan
Company Name and Phone Number_____
Billing Address_____
Name of Insured and Relation to Patient_____
Plan ID Number_____
Name and Phone Number of person to
contact in the case of an emergency_____

I hereby authorize payment of medical benefits billed to my insurance to _____.
I hereby accept
responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees
that exceed the payment made by my insurance, if the Practice does not participate with my insurance.
I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

_____ _____
signature of patient or guardian date

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ , hereby authorize Brent L. Mixon OD, LLC
to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Brent L. Mixon OD, LLC can refuse to treat me.
I have been informed that Brent L. Mixon OD, LLC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.
I understand that I may revoke this consent at any time by notifying Brent L. Mixon OD, LLC, in writing, but if I revoke my consent, such revocation will not affect any actions that Brent L. Mixon OD, LLC took before receiving my revocation.
I understand that Brent L. Mixon OD, LLC has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.
I understand that I have the right to request that Brent L. Mixon OD, LLC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Brent L. Mixon OD, LLC does not have to agree to such restrictions, but that once such restrictions are agreed to, Brent L. Mixon OD, LLC must adhere to such restrictions.

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____ _____
Printed name of patient or patient's representative **Relationship to the patient**