

**HUMMEL EYE ASSOCIATES  
PATIENT INFORMATION FORM**

Mr. Mrs. Miss Ms. \_\_\_\_\_ Today's Date \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Address \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pgr \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Sec # \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**Emergency Contact (someone outside of your household)**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

**INSURANCE (Please present insurance cards & Driver's License at check-in)**

**Who is responsible for this account?**

Name of Policyholder: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policyholder SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address of Policyholder: \_\_\_\_\_

Employer: \_\_\_\_\_

PRIMARY: \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_ Group # \_\_\_\_\_

SECONDARY: \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_ Group # \_\_\_\_\_

Do you have vision plan benefits? Yes No If so, plan name? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**How have you heard about Hummel Eye Associates?**

Radio (which one) \_\_\_\_\_ Website: \_\_\_\_\_

Health Fair \_\_\_\_\_ Yellow Pages (which one) \_\_\_\_\_

Letter/Mailed Offer \_\_\_\_\_ Insurance Plan \_\_\_\_\_

Other: \_\_\_\_\_

**Please turn over, read other side and sign as indicated**

**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

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 shall honor that 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, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- I have the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- I may revoke this Consent in writing at any time and all future disclosures will then cease
- A photocopy of my signature may be used to process my Medicare/insurance claim
- My signature below authorizes my carrier to issue insurance benefits payable on my behalf for services rendered directly to Hummel Eye Associates and/or the physician providing the service on my behalf
- I am responsible for personal payment of any amount not covered by insurance. Co-pays are due at time of service and if billed, the patient will be charged a \$20 fee for handling and processing
- I am responsible for any charges denied by insurance because I failed to disclose my participation in an HMO, PPO or other contracted network PRIOR to services being provided
- Dr Hummel may schedule your procedure at Oklahoma Surgicare. He is part owner in the facility. He hopes you will provide feedback on the quality of care you receive there. Dr Sylvester may schedule your procedure at Foundation Surgery Center. She is part owner there and also hopes you will provide feedback on the quality of care you received.
- The Practice may condition treatment upon the execution of this Consent

Patient Signature: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Patient or Representative Date

Relationship to Patient (if other than patient): \_\_\_\_\_

