ESTACADA VISION CLINIC Date

PATIENT (please print)

NAME: LAST, FIRST, M.I.			SOC. SEC. NO.	BIRTH DATE
ADDRESS	CITY	STATE	ZIP	HOME PHONE
EMAIL ADDRESS				CELL PHONE
EMPLOYER NAME /OCCUPATION		WORK PHONE	SEX M F	MARITAL STATUS: S M W

PHYSICIANS

PRIMARY CARE PHYSICIAN		CLINIC NAME		
ADDRESS	CITY	STATE	ZIP	OFFICE PHONE

SPOUSE/PARTNER

NAME	EMPLOYER NAME	HOME PHONE	WORK PHONE

CONTACT PERSON (relative or friend to contact in case of emergency)

NAME, RELATION	PHONE
NEAREST RELATIVE NOT LIVING WITH YOU	HOME PHONE

PRIMARY HEALTH INSURANCE		VISION INSURANCE	
NAME		NAME	
ADDRESS		ADDRESS	
POLICY #	GROUP #	POLICY #	GROUP #
EFFECTIVE DATE	GUARANTOR NAME (if different than patient name)	EFFECTIVE DATE	GUARANTOR NAME (if different than patient name)

FINANCIAL AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

Please read and sign the following consents, releases, and agreements:

MEDICARE PATIENTS CERTIFICATION: I request that payment under the medical insurance program be made to The Estacada Vision Clinic (EVC) on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers 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.

❑ Life-Time Authorization Period or ❑ from _____ to _____ (valid until revoked)

ASSIGNMENT OF BENEFITS & PAYMENT AUTHORIZATION: I authorize payment directly to EVC of all benefits otherwise payable by any insurance policy(s) and I hereby irrevocably assign such benefits to EVC in an amount not to exceed the charges for the services rendered. I agree to be financially responsible for charges denied by insurance. If my indebtedness for such charges is placed with an attorney or agency for collection, I agree to pay EVC reasonable attorney's fees and collection expenses.

Patient Signature: _____ Date: _____ Initials of Witness: _____

Please note: Your signature is required by law to allow our physicians to bill your insurance.

CONTINUED ON BACK

NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (CONTINUED):

I understand that The Estacada Vision Clinic (EVC)| may use or disclose my protected health information for the purposes of diagnosing or providing treatment for me, obtaining payment for health care expenses, or to conduct health care operations. "Protected health information" includes information created, maintained or received by TOC that identifies me or from which my identity could be determined, and which relates to my past, present or future physical or mental health, condition, treatment, or payments for medical services.

I acknowledge that I have been provided with EVC|'s Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills or in the performance of health care operations of EVC , as well as my individual rights and the duties of EVC with respect to my protected health information.

EVC| reserves the right to change the privacy practices that are described in its Notice of Privacy Practices. EVC will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting EVC| and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature: _____ Date: _____

Referred By_____