1675 State Route 51
Jefferson Hills, PA 15025
Tel: 412 382 7155
Fax: 412 382 7133

PATIENT REGISTRATION

Pittsburgh EYE Institute

Last Name _____ First Name_____ MI_____ Gender ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____ Home ____Own ____ Rent

Social Security # _____ Birthdate _____ Age ____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Occupation _____ Employer _____ Phone _____

Spouse's Name _____ Employer _____Phone _____

Drug Store Name _____ Drug Store Phone _____

Primary Care Physician _____ Phone _____

Optometrist (if applicable) _____ Phone _____

How Did You Hear About Our Practice? _____

Who Referred You? ☐ PCP ☐ Optometrist ☐ Other Explain: _____

Name of Local Emergency Contact **(Someone not living with you)** _____

Relationship _____ Home Phone _____ Work Phone _____

Primary Insurance _____ Policy # _____ Group # _____ Eligibility Date _____

Secondary Insurance _____ Policy # _____ Group # _____ Eligibility Date _____

Vision Insurance _____ Policy # _____ Group # _____Eligibility Date _____

When ordering frames/lenses a 50% down payment will be required to process your order.

PLEASE HAVE YOUR INSURANCE CARDS READY SO WE CAN MAKE A COPY FOR YOUR CHART. THANK YOU

Workers' Compensation/Auto Accident: If your visit is a result of a workers' compensation claim/auto accident, please ask the receptionist to give you a separate information form so we can help you process your claims.

ADVANCE DIRECTIVE: DO YOU HAVE AN ADVANCE DIRECTIVE? _____ YES _____ NO

Authorization for Care: I hereby give my permission & written consent to **Pittsburgh Eye Institute LLC**, its physicians, optometrists, and employees to render any and all medical/surgical treatment as deemed necessary because of injury/illness.
Lifetime Insurance Authorization: I hereby authorize **Pittsburgh Eye Institute LLC** to release any of my protected healthcare information necessary to process my healthcare claims to all applicable insurances such as Medicare, Medigap and any other health insurance carrier I may have as well as major medical. I authorize and assign all insurance benefits to be payable to **Pittsburgh Eye Institute LLC** on my behalf for any services provided by the physicians, optometrists, or suppliers of this practice. I understand and agree that regardless of any insurance status, I am responsible for any balance on my accounts.

ASK OUR RECEPTIONIST FOR LITERATURE REGARDING ADVANCE DIRECTIVES.

PATIENT'S SIGNATURE (required)_____ DATE _____
Parent if patient is a minor I agree to the above

SPOUSE'S SIGNATURE (required)_____ DATE _____
Trustee/Guardian I agree to the above

If patient cannot sign, please state reason: _____

ALL CHARGES, COPAYMENTS AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. IF YOU ARE EXPERIENCING HARDSHIP WHICH WOULD MAKE PAYMENT IN FULL IMPOSSIBLE, PLEASE FEEL FREE TO SET UP A PAYMENT PLAN WITH OFFICE MANAGER.

1675 State Route 51
Jefferson Hills, PA 15025
Tel: 412 382 7155
Fax: 412 382 7133

Pittsburgh EYE Institute

www.pitteye2020.com

Thomas F Findlan D.O.
Joanna Godlewski O.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By my signature below, I acknowledge that I have received Pittsburgh Eye Institute's Notice of Privacy Practices

Patient signature: _____ **Date:** _____

Patient name (print): _____

This acknowledgement page should be retained in the patient's record. If acknowledgement could not be obtained from patient, the reasons must be documented below.

If you have any questions regarding our HIPAA compliance, please refer to our HIPAA manual in the reception area.

PROTECTED HEALTH INFORMATION RELEASE FORM

In compliance with HIPAA regulations, and in order to facilitate requests for your protected health information, please complete the lower portion of this form.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. Pittsburgh Eye Institute is permitted to share with them test results and information disclosed during my office visits. For copies of medical records, I understand that I will need to sign a separate authorization. Please list below, those individuals that you want to receive your protected health information:

_____ _____
Full name **Relationship**

_____ _____
Full name **Relationship**

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

___ Leaving messages on answering machine at _____.
___ Leaving messages on my work voicemail at _____.
___ Leaving messages on my pager at _____.
___ Leaving messages on my cell phone at _____.
___ Other forms of communication _____.

I understand that I will update Pittsburgh Eye Institute with any changes in the above listed contact numbers. I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Patient Signature **Date**

_____
Patient Name (print)

_____ _____
Witness Name **Date**