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

1533 Lincoln Way
White Oak, PA 15131
Tel: 412 672 9765
Fax: 412 672 6902

PATIENT REGISTRATION

Last Name ____________ First Name ____________ MI ______ Gender ☐ M ☐ F

Address ____________ City ____________ State ______ Zip ____________

Home Phone ________ Cell Phone ________ Email ____________ Home ☐ Own ☐ Rent

Social Security # ________ Birth Date ________ Age _____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Pharmacy Name ____________ Pharmacy Address ____________

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 ____________

ADVANCE DIRECTIVE: DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ Yes ☐ No

INSURANCE INFORMATION		
Primary insured subscriber's name:	Primary insured's Social Security #:	Primary Birth date: / /
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Secondary insured subscriber's name (if applicable)	Secondary insured's Social Security #:	Secondary Birth date: / /
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		

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. There will be a $35 fee on all returned checks. **Initials** ________

Charges, copayments and/or deductibles are due at the time of service. If you are experiencing hardship which would make payment impossible, please see the office manager to set up a payment plan.

PATIENT'S SIGNATURE (required) ____________ DATE ____________
I agree to the above

TRUSTEE/GUARDIAN SIGNATURE (if applicable) ____________ DATE ____________
I agree to the above

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Thomas F. Findlan D.O.
Joanna Godlewski O.D.
www.pitteye2020.com

AKNOWLEDGEMENT 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 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**