Pittsburgh Eye Institute LLC

Last Name _____ First Name _____ MI _____ Gender ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary 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 _____

Who referred you? ☐ PCP ☐ Optometrist ☐ Other Explain: _____

Name of local emergency contact (**someone not living with you**) _____

Relationship _____ Cell Phone _____ Home Phone _____

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

INSURANCE INFORMATION		
Primary insured subscriber's name/ Relationship:	Primary insured's Social Security #:	Primary Birth date: / /

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. **Charges, copayments and/or deductibles are due at the time of service.** **Initials** _____

Patient/Trustee/ Guardian's Signature_____ **Date** _____

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

Signature_____ **Date**_____

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.

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. 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 Names	**Relationship**
_____	_____
_____	_____

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**_____