Pittsburgh Eye Institute LLC

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Mobile _____ Home _____ Social Security # _____

Date of birth _____ Email _____ Gender Male ☐ Female ☐

May we Text ☐ Phone _____ May we Email ☐ _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you: ☐ Own or ☐ Rent your home?

Primary Care Physican _____Address _____

Office _____ Fax _____ Referred by: PCP _____

Optometrist _____ Other Explain _____

Name of local emergency contact preferably someone **NOT** living with you:

Name _____ Relationship _____ Primary phone _____

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

Minor under the age of 18 – Responsible party information REQUIRED			
Name / Relationship:	Social Security number:	Address if different:	Date of birth:

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 _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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** _____