Nethery Eye Associates

Patient Name _____ **DOB**_____

Address_____ **City**_____ **Zip code**_____

Email_____

Cell Phone_____ **Alt. Phone**_____

Recent Eye Surgeries_____

New Medications_____

Emergency Contact_____ **Phone**_____

Primary Care Physician _____

I hereby authorize my doctor to release to the Social Security Administration or other insurance carriers any medical or other information needed for all services that I receive. I request that all insurance payments be made directly to my doctor. I understand if my insurance does not pay within 45 days or decided the service is "non-covered" that a bill will be sent directly to me. I further understand that I am responsible for any deductibles, co-insurance, and refraction fees at the time of service.

Signature_____**Date**_____

I also understand that, if at any time, I change my insurance to a managed care plan (i.e. Secure Horizons or any other comparable plan) or change my primary physician, I am responsible for notifying your office of such change. If I fail to obtain a valid referral prior to my visit and I decide to be seen by Nethery Eye Associates, I understand that my services will be considered out of network and I will be solely responsible for the fees incurred.

Signature_____**Date**_____

NOTICE of PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative **Date**

Please list the names of the persons you Authorize Nethery Eye Associates to communicate with regarding your medical care.

_____

Name **Relationship**

_____

Name **Relationship**

_____

Name **Relationship**