HATTIESBURG EYE CLINIC, P.A.
100 West Hospital Drive • Hattiesburg, MS 39402
(601) 268-5910 • www.hattiesburgeyeclinic.com

Today's Date _____

Account # _____

PATIENT INFORMATION:

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Sex _____ Social Security # _____ Marital Status _____

Street Address _____ Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Email Address _____ Referring Dr. _____

EMPLOYMENT INFORMATION:

Patient Employer _____ Occupation _____

Employer Address _____ City _____ State ____ Zip Code _____

SPOUSE INFORMATION: Full Name _____

Spouse Social Security # _____ Spouse Date of Birth _____

Spouse Cell Phone ( ) _____ Spouse Work Phone ( ) _____

Spouse Employer (Name and Address) _____

WORKMAN'S COMP INFORMATION:

Date of injury _____ Place of injury _____

Person to contact: _____ Phone ( ) _____

EMERGENCY CONTACT (NOT LIVING WITH YOU):

Name _____ Phone ( ) _____

Address _____ Relationship: _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR):

First Name _____ Middle Name _____ Last Name _____

Street Address _____ Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Employer's Name _____ Work Phone ( ) _____

Employer Address _____ City _____ State ____ Zip Code _____

INSURANCE INFORMATION (GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY):

(Please check all appropriate boxes)

❑ No Insurance/Self pay ❑ Medicare ❑ Medicaid ❑ UHC ❑ BCBS ❑ Tricare

❑ Medicare Advantage Plan ❑ Vision Plan ❑ Other Insurance ❑ Workman's Comp

Primary Insurance: _____ Secondary Insurance: _____

Insured's Name _____ Insured's Name _____

Insured's DOB _____ Male/Female Insured's DOB _____ Male/Female

Over for Signature

INSURANCE AUTHORIZATION:

INSURANCE AND/OR MEDIGAP ❑

I, the undersigned, authorize payment of medical benefits to this physician, for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

DATE _____ SIGNED _____ *Lifetime Signature

MEDICARE ❑

I, the undersigned, understand that this clinic accepts assignment of Medicare. I agree to be responsible for my deductible and/or any uncovered charges as well as 20% of the allowance of covered services. I request that payment of authorized Medicare benefits be made either to me or on my behalf to this physician for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Center for Medicare Services (CMS) and its agents any information needed to determine these benefits or benefits payable for related services.

DATE _____ SIGNED _____ *Lifetime Signature

MEDICAID ❑

I agree to be responsible for any service not covered by Medicaid. I request that payment of authorized Medicaid benefits be made on my behalf to this physician. I authorize any holder of medical or other information about me to release to the Division of Medicaid or its Fiscal Agent any information needed to determine these benefits payable for related services.

DATE _____ SIGNED _____ *Lifetime Signature

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Hattiesburg Eye Clinic, P.A. and Hattiesburg Eye Clinic Cataract & Lasik Surgery Center, LLC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Hattiesburg Eye Clinic, P.A. and Hattiesburg Eye Clinic Cataract & Lasik Surgery Center, LLC.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity: Relationship:

_____ _____

_____

_____

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to Hattiesburg Eye Clinic, P.A. and Hattiesburg Eye Clinic Cataract and Lasik Surgery Center, LLCs' use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____ Signature of the Patient or Patient Representative

I have been provided a copy of the HEC Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____ Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Hattiesburg Eye Clinic, P.A. and Hattiesburg Eye Clinic Cataract & Lasik Surgery Center, LLC.

_____ Signature of the Patient or Patient Representative