Patient Identification- Please Print				
First:	Middle:	Last:		
Date of Birth:	Address:		Apt # :	
City:	State:	Zip:	Social Security #:	
Primary Phone:				
Emergency Contact:	Phone:			
Referred By:	Email Address:			
Insurance Card Holder - Guardian for Minors				
First:	Middle:	Last:		
Address:	City:	State:	Zip:	
Primary Phone:				
Date of Birth:	Relationship to Patient:	Social Security #:		
Please Present Insurance Cards and Photo ID to Receptionist				

I consent to treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. Refractions are not typically covered by insurance or government programs and are the patient's responsibility.

I understand that proof of insurance must be presented at the time of service. I will provide valid insurance information on the day of service. If no insurance information is provided, I understand that payment is due the day of service, and no insurance billing will be provided at a later date.

I authorize and request that insurance payments be made directly to Clear Image Eye Center should they elect to receive such payments.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. In the event, the charges incurred are not paid in full when due and collection action is instituted, whether by a collection agency or attorney, or both, I agree to be responsible for and pay, in addition to the charges for services and treatment received, all costs associated with such collection activity. These costs include, but are not limited to, reasonable collection agency fees, attorney fees, court cost and/or any other expenses incurred in its collection. I also agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone number, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or of an automatic dialing device, as applicable. I have this disclosure and agree that the Physician/Collection Agency may contact me as described about.

_____ _____

Patient Signature Date

Clear Image Eye Center

Notice of Privacy Practices:

I hereby acknowledge the receipt of Notice of Privacy Practices from Clear Image Eye Center.

Signature of the Patient/Guardian	Relationship	Date

Authorization for Use and Disclosure of Protected Health Information:

Persons to Whom Information May be Disclosed:
We can not disclose any information to anyone other than the patient unless listed below.

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

Right to Terminate or Revoke Authorization
This authorization will remain valid unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Clear Image Eye Center. You should contact Kristi Meiring, Privacy/Compliance Officer, to terminate this authorization.

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature of the Patient/Guardian	Relationship	Date

Notice to Clear Image Eye Center Patients Regarding Optomap Retinal Imaging and Dilation of Your Eyes

We pride ourselves on providing our patients with the best possible standard of care. We now perform the optomap retinal exam on all of our patients. As part of your pre-test work up, we will capture optomap images today. There is a $20 charge for this procedure. **With optomap imaging, the doctor may not need to dilate your eyes.**

I have read and understand optomap imaging:

Initial _____

It may be necessary to **dilate your eyes**. The dilating drops may cause blurred vision, light sensitivity, inability to read or drive safely. These problems go away as the effects of the drops wear off. You should be careful walking, going up and down stairs, and driving.

You may elect to bring or call a driver if you feel the need. Also, for your comfort, dark glasses or inserts are located at the reception desk.

I have read and understand dilation:

Initial _____

_____ _____

Signature of Patient Date

_____

Parent or Guardian

Revised 08/10/2018