Name:	**DOB:**	**SSN:**	
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		**Marital Status:**
Can we send you email reminders? If yes, please include email below: **Email:**		**Employer:** **Occupation:**	
Insurance Subscriber's Name, DOB & Last 4 of SSN:			

Responsible Party Information is REQUIRED if Patient is a Minor.

Name:	**DOB:**	**SSN:**	**Relationship to Patient:**

HIPAA CONSENT & AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand as part of my health care, Downtown Eye Care physician(s) originate and maintain health records describing health history, symptoms, examination, test results, diagnoses, and treatment plans. I understand that this data is used to plan for treatment, bill for services, routine healthcare operations & communicate with other healthcare providers.

I acknowledge that I have been provided access to the Notice of Privacy Practices of Downtown Eye Care. DEC's Notice of Privacy Practices explains to me use and disclosure of my protected health information (PHI). I understand that DEC reserves the right to change the terms of this notice from time to time and that I may contact DEC at any time to obtain the most current copy. I understand that I have the right to restrict the use and/or disclosure of my PHI for treatment, payment or healthcare operations and that DEC is not required to agree to the restrictions requested. Unless otherwise revoked, the authorizations and/or restrictions defined below will expire on the following date, event or condition. If I do not specify an expiration date, event or condition, this authorization will expire one year from today's date. Date: _____

RELEASE OF INFORMATION: I hereby authorize Downtown Eye Care to convey information about my health to the following person(s):

Name: _____Phone:_____Relationship:_____

Name: _____Phone:_____Relationship:_____

Name: _____Phone:_____Relationship:_____

*If no one is listed above, arrangements must be made ahead of the release of any eyeglass or contact lens materials.

Restrictions: You have the right to request restricted use and disclosure to certain individuals, Downtown Eye Care, is allowed by law to deny any request that impedes treatment, payment, or healthcare operations. Please list any restrictions below:

Name(s):_____Reason:_____

STATEMENT OF RESPONSIBILITY: I hereby consent to rendering of medical/vision care, which may include routine diagnostic procedures, testing, and medical procedures performed by authorized physicians or staff members of DEC.

Payment is due from the patient at the time services are rendered. Patients are responsible for any applicable co-payments and/or deductibles.

I understand terms are for services rendered; I will be responsible for all charges incurred by me and/or my dependents. Should collection proceedings become necessary, I agree to pay all costs of collection, including a reasonable attorney's fee. I hereby assign to and authorize payment directly to Downtown Eye Care. If insurance is filed by DEC, I realize the insurance benefit may not pay the entire bill and agree to pay the difference or the entire bill, if necessary. I authorize the release of medical information necessary to process my insurance claims or to continue my medical care. DEC's employees and/or agents have "expressed prior consent" to use any contact information (home or cell phone, and email) supplied by me to notify me of appointments, spectacle and/or contact lens dispensing, referrals or billing matter.

An itemized statement for insurance purposes will be furnished upon request after payment for services have been made or services rendered. All of the information I have provided is complete and correct to the best of my knowledge.

_____

Patient Signature or Responsible Party and Relation to Patient **Date**