PATIENT PROFILE (Please Print)

DATE:	
OFFICE:	
OPTOMETRIST: Cameron D. Seidel, OD	

Name:	Home Phone:	Work Phone:	
Address:	Birth date:	Occupation:	
City:	State:	Zip:	
Date of Last Exam:	Location of Last Exam:	How did you hear about us?	
Employer:	Insurance Carrier:		Group No.:
Driver's License #:	Primary Insured ID#:		
Reason for Today's Exam:			
What type of exam are you here for? Glasses ☐ Contacts ☐ Both ☐			
Do you presently wear glasses? Yes ☐ No ☐	Do you wear contact lenses now? Yes ☐ No ☐		
Have you ever worn contact lenses? Yes ☐ No ☐	Are you sensitive to light? Yes ☐ No ☐		
Are you interested in trying contact lenses? Yes ☐ No ☐			
Are you having problems with your present eye wear? Yes ☐ No ☐			

What type of work do you do? _____

How many hours a day do you spend at a computer terminal? _____

Hobbies, Interests, or Sports? _____

	Yes	No
Do you have any medical problems? Describe: _____	☐	☐
Do you take any medication? List: _____	☐	☐
Do you have any allergies? List: _____	☐	☐
Do you have frequent headaches? _____	☐	☐
Do you ever see double? _____	☐	☐
Do you or any family member have Diabetes? Who? _____	☐	☐
Do you or any family member have Glaucoma? Who? _____	☐	☐
Do you or any family member have Cataracts? Who? _____	☐	☐
Do you or any family member have Macular Degeneration? Who? _____	☐	☐
Does any family member have an eye disease? Who? _____	☐	☐
Describe: _____		
Have you ever had any eye disease, eye injury, or eye surgery? _____	☐	☐
Describe: _____		

Consent for release of information to the below listed parties for payment and/or insurance benefit-claims purposes; Responsibility for Payment Notification

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- **I consent to the use and disclosure by the Office and any information, e.g. health information concerning my vision examinations and products, to any party and/or agent, including, but not limited to my employer, health plan or plan sponsor ("Plan"), as needed for my treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the Office (e.g. mailings of appointment reminder or recall cards, billing and payment collections, or explanations of services/products provided by the Office).**
- **If I desire to seek third party reimbursement for the services received, I authorize the Office to submit a vision benefit claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any/all third party(s).**
- **I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the Office in writing except for any disclosure already taken in reliance of my consent to release information. I understand that I may request the Office to restrict the use and disclosure of my information; however, the Office is not required to agree to my request unless my request is submitted in writing. Should I choose to revoke this consent, I understand that I am responsible for any/all charges billed to my account regardless of my third party/insurance claim status.**
- **I understand that any charges billed to me are due at the time of service unless other payment arrangements have been made. I understand that all charges billed to any minor children in my dependency are my responsibility. I understand that should I fail to meet my payment obligations the following may/will occur at the discretion of the office: a monthly finance charge of 1.5% - 18% annually ($1.00 minimum) on any balance due will be billed to me; should my account fall 90 days or more past due or should at anytime my account be processed for Non-Sufficient Funds (NSFs); I will be subject to collections proceedings at the discretion of the office.**

Patient's Name **Date of Birth (MM/DD/YYYY)**

Signed (Patient or Legal Representative for Patient) **Date**

Legal Representative's Relationship to Patient

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

***Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**

***Obtain payment from designated third-party payers.**

***Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.**

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in office in print form or on the office website (www.prossereyecare.com). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name **Date of Birth (MM/DD/YYYY)**

Signed (Patient or Legal Representative for Patient) **Date**

Legal Representative's Relationship to Patient

Cameron Seidel, O.D.
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(509) 662-2653