PATIENT'S FIRST NAME, MIDDLE INITIAL AND LAST NAME	BIRTHDATE

The Center of Medicare and Medicaid Services requires that we collect the patient's race, ethnicity and primary language

RACE	Hispanic or Non-Hispanic (circle)	LANGUAGE:

PATIENT GENDER :	FEMALE	MALE	SOCIAL SECURITY # (REQUIRED)

FULL ADDRESS (MUST INCLUDE STREET, CITY, STATE AND ZIP CODE)

EMAIL

MOBILE PHONE #	HOME PHONE NUMBER	PREFERRED METHOD OF CONTACT: PHONE EMAIL

PREFERRED PHARMACY: (NAME AND ADDRESS)

PRIMARY MEDICAL INSURANCE:	SECONDARY MEDICAL INSURANCE:

VISION INSURANCE: (FOR OPTICAL SERVICES ONLY)

PRIMARY CARE DOCTOR	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER
REFERRING DOCTOR'S NAME (IF DIFFERENT)	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

Authorization to Release Health Information to Family/Friends

To make it easier to discuss medical care about you with those that help you with care, we ask that you complete this form. Example of who needs permission for us to talk to would be spouses/partners, children, parents, aunts/uncles, siblings, friends, neighbors etc. I AUTHORIZE:

PERSON'S NAME: _____RELATIONSHIP: _____ PHONE #: _____

PRESON'S NAME: _____RELATIIONSHIP: _____PHONE#: _____

GUARDIAN INFORMATION IF ADULT PATIENT IS DEVELOPMENTALLY DELAYED

Parent/Guardian's last name	First Name	Relationship to Patient	Birthdate	Social Security #
Parent/Guardian's Last Name	First Name	Relationship to Patient	Birthdate	Social Security #

Nicholas Sala, D.O.

Wesley Cox, O.D.

PAYMENT FOR SERVICES

PATIENT RESPONSIBILITY – You will be responsible for co-pays and any balances not covered or paid by insurance. Routine eye care is not covered by many insurances. Therefore, if there is not a medical diagnosis, we ask that you pay at the time of service. We will still bill your insurance for you and if they do pay, you will receive a refund. If you do not have insurance, you are responsible for the full amount of fee at the time of service. We do accept credit/debit/HSA cards/checks and cash.

The parent/guardian who brings the child to the office is ultimately responsible for payment of the fees regardless of who the insured party is. If a person other than a parent brings a child, they are responsible for payment of the fees at the time of service unless they have all of your insurance information including a copy of the insurance card that includes a billing address.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION – I authorize the release of any medical information acquired or required during the course of the examination and ongoing treatment by Pediatric Ophthalmology of Erie. I understand that Pediatric Ophthalmology of Erie will correspond with and may otherwise convey information regarding patients' medical status to the referring physician, the primary care physician and insurance companies requested.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS – I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Pediatric Ophthalmology of Erie. I authorize the release of any medical and/or other information necessary to process the claim.

NOTICE OF IMPAIRED VISION- I understand that the examination I received may impair my vision and/or operation of mechanical equipment. I also realize that I may be unable to react with normal speed and accuracy. I have been advised that a driver should accompany me. I will make arrangements for my own transportation.

OUR OFFICE POLICY REQUIRES THAT THIS FORM MUST BE COMPLETED IN ITS ENTIRETY!

_____ (INITIAL) I have received Pediatric of Ophthalmology of Erie's Notice of Privacy Practices and I have been provided the opportunity to review it. (Located on website)

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE PRECEDING DOCUMENT AND THAT THE INFORMATION I HAVE PROVIDED IS CORRECT.

Signature_____ Date _____

Patient's Printed Name: _____