GRAHAM
EYE CARE

Name: _____ SSN: _____

Mailing Address: _____

City/State/ZIP: _____DOB:_____

Email Address: _____

Home #: _____ Work #: _____ Cell #: _____

Preferred method of contact: Home Work Text Email

HIPPA Authorization Information

By signing below I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly; obtain payment from third-party payers; and conduct normal healthcare operations such as quality assessments and physician certifications. I acknowledge that I have received a copy of Graham Eye Care's Notice of Privacy Policy, and I agree to the office financial policies.

_____ _____

Signature of Patient or Patient Representative **Date**

Insurance Information *Please provide all vision and/or medical insurance **prior** to your eye exam.*

Your signature below gives Graham Eye Care the permission to file an insurance claim on your behalf. In the event that your insurance states that you are not eligible for coverage at the time of service, or determines that you are eligible for a reduced level of coverage, by signing this statement, you hereby agree to be financially responsible for any and all charges incurred by you that are not paid by your insurance provider.

_____ _____

Signature of Patient or Patient Representative **Date**