We appreciate you being our patient! 2019

Please fill out this form as completely as possible. In compliance with insurance requirements, yearly updates are required. This information will allow us to begin the process that ensures your eye health and vision remain at their best. Thank you for your help.

Miss / Mrs. / Ms. / Mr. / Dr. / Rev.

Name: _____
Last First Middle Nickname or Preferred

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

Date of Birth: _____/_____/_____ **SS#:**_____-_____-_____

☐ **Male** ☐ **Female** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Race: ☐ **American Indian** ☐ **Asian** ☐ **Black or African American** ☐ **Hispanic** ☐ **Native Hawaiian or other Pacific Island** ☐ **White**

Ethnicity/Heritage: ☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino** ☐ **Hawaiian / Other Pacific Island**

Cell: (_____) _____-_____ **Home:** (_____) _____-_____ **Work:** (_____) _____-_____

e-mail: _____ Best way to contact me: ☐ **email** ☐ **postal service** ☐ **telephone** ☐ **text**

Your Employer/ phone number _____ **Your Family Doctor** _____

Your Preferred Pharmacy _____ Where is it? _____

If married, name of spouse _____ Spouse employed by _____

Spouse Date of Birth: _____/_____/_____ Spouse **SS#** _____-_____-_____

If under 18, parent or guardian's name _____**Relation to minor** _____ **Phone (_____)** _____-_____

Employer: _____ **Date of Birth:** _____/_____/_____ **SS#:**_____-_____-_____

Why did you choose our office? _____ **Whom may we thank for referring you?** _____

Emergency Contact: _____ Number: (_____) _____-_____

*** INSURANCE INFORMATION ***

How will you be paying today? ☐ **Full payment by cash, check, credit card or Care Credit** ☐ **Medical or Vision Care insurance with deductible**

Insurance information must be presented at time of visit, and cannot be changed after date of service due to electronic filing.

Policy Holder Name_____ **SS#**_____-_____-_____ **Date of Birth**_____/_____/_____

Primary Insurance Company_____ID#_____Group #_____

Secondary Insurance Company_____ID#_____Group#_____

Policy Holder's Relationship to Patient_____

I, the undersigned, certify and assign to Dr. Christopher J. Moshoures, Optometrist, PA (Vision Square Eye Care) all insurance benefits. **I understand that I am financially responsible for all charges not paid by my insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for any and all collection methods. I authorize the doctors to treat me or the patient I am authorized to give permission for and understand that this authorization can only be rescinded by written notice.

_____ _____
Signature Date

Vision Square Eye Care 2019

Dr. Chris Moshoures Dr. Kathy DesLauriers Dr. Beth Cooke Dr. Debra Webb Dr. Stephanie Hardy

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NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF PHI

A federal regulations known as the "HIPAA Privacy Rule" requires that we provide you a detailed notice in writing of privacy practices. This notice is available to all patients who ask to read it. In this notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient or where there is a reasonable basis the information can be used to identify a patient. This information is called "protected health information" or "PHI". Below you can request how Vision Square Eye Care communicates information to you. You may also request that only certain individuals be given information about your health, treatment or other personal information. ***Please fill out the questionnaire below.

PLEASE CONTACT ME IN THE FOLLOWING MANNER: Please circle your preferences

HOME PHONE: _____ **CELL PHONE: _____**

Leave detailed message on VOICE MAIL **Y N** ***Leave detailed message on VOICE MAIL*** **Y N**

Leave detailed message with a PERSON **Y N** ***Leave detailed message with a PERSON*** **Y N**

Name of Individual: _____ **Name of Individual: _____**

• A call back message stating the office called, a contact name and telephone number will be left at the numbers that you have answered NO.

WORK PHONE: _____ ***Leave detailed message on PERSONAL VOICE MAIL*** **Y N**

- **Messages will not be left with a person at your work telephone unless you specifically indicate the name of the individual in the following space: _____**
- **ALL correspondence mailed will be in a sealed envelope addressed only to you, the two (2) exceptions are post cards to notify you that you have an appointment or that products are ready for you.**

I authorize Vision Square Optometrists and/or staff to discuss my PHI with the following individuals:

Name _____ Relationship _____Phone _____

Name _____ Relationship _____Phone _____

Name _____ Relationship _____Phone _____

I acknowledge that I have been given the opportunity to read Vision Square Eye Care Notice of Privacy Practices and understand that the above will remain in effect until revised by me.

Patient/Legal Representative Signature: _____ Date _____

Staff Member Witness: _____ Date _____

GREEN YELLOW RED