Tennessee River Eye Clinic

Patient Information

Name _____ Birth Date _____SSN _____

Address _____City _____ST _____ Zip _____

Cell #_____ home_____ work/other_____ Email_____

Sex: M F Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Race: [ ] Decline [ ] Caucasian [ ]Black [ ]African American Other_____

Preferred Language: [ ] English [ ] Spanish Other:_____ Ethnicity: [ ] Decline [ ] Hispanic [ ] Non-Hispanic

Occupation _____ Employer_____ Phone_____

Spouse's Name _____Birth Date _____SSN _____

Employer_____ Phone_____

Responsible Party

[ ] Patient [ ] Spouse [ ] Parent/Guardian [ ] Male [ ] Female

Name_____BirthDate_____SSN_____

Street address_____City_____ST_____Zip_____

Cell #_____ home_____ work/other_____ Email_____

Insurance (We will copy your insurance card)

Primary care doctor _____Eye care doctor_____

Emergency Contact

[ ] Spouse [ ] Parent/Guardian Name _____Relationship _____Cell_____

24-hour notice is required for all cancellations

After 2 missed appointments, it will be documented in the patient's chart and a fee of $50 will be assessed to the patient's account and may ultimately result in dismissal from our practice.

Best possible vision measurement or RX. This is a medically non-covered service. The fee is $30.00 and is collected at time of service. We only collect if service is performed.

I authorize the release of any medical information necessary to process a claim on any insurance policy on file. I hereby assign to and authorize payment directly to Tennessee River Eye Clinic/Mark Kassels M.D./Jan Lenz O.D. of all benefits payable under Medicare, Medicaid or other insurance policy as well as any MEDIGAP Insurance. I understand that I am ultimately responsible for all charges, whether or not paid by my insurance. I also understand that, should I default on my account, all costs of attorney's fees, interest and cost of collections would be my responsibility.

Patient/Responsible party
signature_____Date_____

Tennessee River Eye Clinic

Patient Information

Notice of Privacy Practices and Patient Consent

For Use and Disclosure of Protected Health Information

Patients Name(Print) Date of Birth SSN

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Tennessee River Eye Clinic may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Tennessee River Eye Clinic has a detailed document called the ***Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how me may use and disclose protected health information.

I understand that I have the right to read the ***Notice of Privacy Practices***.

My signature below indicated that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Tennessee River Eye Clinic to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Tennessee River Eye Clinic has taken action relying on this consent.

Patients signature (or Authorized Representative) Date

Witness signature Date

You may obtain a copy of out ***Notice of Privacy Practices***, including any revisions of our Notice at any time by contacting 256-381-2020.