



WELCOME TO ST. CLAIR EYE OF SHELBY

Appointment Date: _____

Name: _____ D.O.B. _____ Age: _____ M or F _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Married / Single / Divorced If Minor – Parents Name: _____

Home Phone: _____ Cell: _____ E-Mail: _____

Emergency Contact: _____ Phone: _____
Name Relationship

Employer: _____ Occupation: _____ Work # _____

Referred By: _____ New Patient: Yes / No

Vision Insurance: _____ Contract # _____ Group # _____

Members Name: _____ Members DOB: _____

Members Employer _____

Relationship of Patient to Member: Self / Spouse / Child / Other (Circle One)

Medical Insurance: _____ Contract # _____ Group # _____

Members Name: _____ Members DOB: _____

Relationship of Patient to Member: Self / Spouse / Child / Other (Circle One)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability 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, plans and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 to obtain a current copy of the *Notice of Privacy Practices*.

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

Print Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient _____ (If under 18 years old)