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 ("HIPPAA"), 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)

9/1/10