HUDSON VALLEY EYE ASSOCIATES

914-345-3937

Patient Information

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____ Name and Address of Pharmacy: _____

Age _____ Birthdate _____ SS# ___ - ___ - _____ Sex ❒ Female ❒ Male

Marital Status _____ Maiden Name _____

Responsible Party (if Patient is under 18) _____

Race
❒ Declined to Provide

Ethnicity
❒ Hispanic or Latino
❒ Not Hispanic or Latino
❒ Declined to Provide

Language
❒ Declined to Provide

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Physician _____ Phone _____

Address _____
Street & Apt # City State Zip

Referring Physician _____ Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Policy Holder:
Name _____ DOB _____ Relationship to Patient _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Policy Holder:
Name _____ DOB _____ Relationship to Patient _____

I hereby authorize the release of any medical information necessary to process my insurance claim and request direct payment to be paid to the above Hudson Valley Eye Associates. I authorize the physicians to proceed with my care and will be responsible for any co-payment or non-covered services. Any such payment will be required at the time of services rendered. I agree to provide any necessary REFERRAL or AUTHORIZATION at the time of my visit. If I fail to do so, I understand that I will be PERSONALLY financially responsible for the care provided. **I have read and understand the above statements.**

Signature _____ **Date** _____

PLEASE COMPLETE HIPAA RELEASE FORM ON REVERSE OF THIS SHEET

HUDSON VALLEY EYE ASSOCIATES

914-345-3937

I understand that, under the Heath Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights and privacy regarding my protected health information. I understand 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.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Hudson Valley Eye Associates will provide a copy, upon request, of their 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 at the address above 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____