*Biloxi • Fairhope • Foley • Gulf Breeze • Mobile • Pensacola • Saraland • Spanish Fort • South Foley*

Salmedina Alic, OD | Donna Corder, MD | Ayesha Kidd, OD | Paul McDaniel, DO | Hong Nguyen, OD | Courtney Ray, MD
Ray Rojas, MD | Gayla Rowland, MD | Dan Wilder, OD | Taylor Wolkart, OD | Peter Zloty, MD

## PATIENT INFORMATION

Name ____________________________________
Address __________________________________
City __________________ State ____ Zip _________
Phone # (     ) ____________________________
Cell # (     ) _____________________________
Email ____________________________________
How did you hear about us? ___________________
Referring Doctor ____________________________
Primary Care Physician _______________________
Social Security # ___________________________

Date of Birth ____________________ Age __________
Gender: Male Female
Race: _____________________________________
Ethnicity: __________________________________
Language: __________________________________
Marital Status: Single Married Widowed Divorced
Emergency Contact ____________________________
Emergency Phone # (     ) ______________________
Relationship _________________________________
Are you employed? Yes/Where? ___________ No Retired

## INSURANCE INFORMATION

Primary Insurance Co ___________________________
Policy Holder Name ____________________________
Policy # ________________Policy Holder DOB ________

Secondary Insurance Co _________________________
Policy Holder Name ____________________________
Policy # ________________Policy Holder DOB ________

Vision Insurance Co ____________________________ Policy Holder Name ____________________________________
Last 4 Digits of Policy Holder SSN __________________ Policy Holder DOB ______________

## RESPONSIBLE PARTY

- I authorize and consent to the professional services rendered to the above patient. Authorization is given to release information as may be necessary for the completion of medical insurance claims, the benefits of which may be assigned to the physician at his option.
- I agree to pay interest on any uncollected amount of debt to **Bay Eyes Cataract & Laser Center, P.C.** I agree to pay the cost of collection for past due debt. I acknowledge responsibility for the payment of services rendered and agree to pay for them at the time of service. Co-pays, fitting fees, and refractions not covered by insurance will be paid at the time of service.
- By signing below, you hereby consent for this practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment, and healthcare operations. You may refuse to share your information.
- You should read the Notice of Privacy Policies for PHI located at the front desk or the lobby copy provided at the doctor's office before you sign the consent form. If you would like a personal copy, please ask the front desk receptionist. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer of this practice.
- You have the right to request that this practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. This practice is not required to agree to requested restrictions; however, if the practice does agree to your requested restrictions, the restriction is binding on it.
- Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to the consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.
- You may communicate with the following individual(s) regarding my condition or course of treatment(s):

  ______________________________________________________________________________
- You may communicate confidential information to me at the address and phone numbers listed above or at the following:

  ______________________________________________________________________________

**Patient Signature (or Responsible Party)** _________________________________________ **Date** ________________