GRIFFIN EYE CENTER

Name: _____ DOB: _____

PATIENT REGISTRATION

PREFERRED PHARMACY	Street Address	City	State	Phone #
PRIMARY CARE PHYSICIAN	Street Address	City	State	Phone #
Other Physician's Name and Specialty	Street Address	City	State	Phone #

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:
I authorize my physician and/or administrative and clinical staff of Griffin Eye Center to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name: _____ Relationship_____

Name: _____ Relationship: _____

I give Griffin Eye Center permission, should it be needed, to share my diagnostic images and health information with outside providers and diagnostic experts in order to coordinate my care and/or treatment using electronic means, including but not limited to fax, email, Dropbox.

Signature of the Patient or Patient Representative: _____

I have been offered a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

Signature of the Patient or Patient Representative: _____

I understand that it is the Financial Policy of Griffin Eye Center, that I, the patient and/or the patient's representative, am responsible for all payments that are not covered by my insurance company, included but not limited to, my co-pay, co-insurance, deductibles and non-covered services/procedures. I also acknowledge that non-payment of my account may result in collection proceedings and/or dismissal from the practice.

Signature of the Patient or Patient Representative: _____

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Griffin Eye Center.

Signature of the Patient or Patient Representative: _____

Patient Representative:
Name: _____ Relationship: _____

Signature: _____ Date: _____

Are you the Official Medical Power of Attorney: YES NO POA Document Provided: Yes NO

Please note that in situations where the patient is not medically able to sign for themselves we will need to have a copy of the official power of attorney document prior to consenting for surgical procedures.