PLEASE PRINT Date _____

STANDARD PATIENT INFORMATION FORM

Patient's full name _____ Phone _____

Address _____ City _____ St ____ Zip _____

Age _____ Date of birth _____ Social Security number _____

Employer _____ Business phone _____

Employer's address _____ City _____ State _____

Name of spouse _____

Spouse employed by _____ Business phone _____

Employer's address _____ City _____ State _____

If patient is a minor,

Give parent's name _____

Parent's employer _____ Business phone _____

Employer's address _____ City _____ State _____

Person to pay for services _____

If paying for services by check,

Please give Driver's License number _____ State _____

Referred by _____ Address _____

Medical physician _____ Address _____

Former eye physician _____ Address _____

If insured,

Give name and address of company and policy number _____

_____

In case of emergency, who would we contact _____

**All visits are on a cash basis, unless prior arrangements have been made.*

_____
Signature

FORM # SPIF-3211 REV. 8/99

SOUTHWEST
RETINA
EYE CENTER

Jose Mayans, M.D.

We welcome you as our patient and appreciate the opportunity to participate in your health care. We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and community.

If you have health insurance, it should be understood that this is an agreement between you and an insurance company to pay you certain amounts for medical care. Your doctor's bill is an agreement between you and your doctor. You are responsible for the payment of your bill regardless of the status of your insurance claim.

For our private pay patients: You are responsible for all charges on your first visit. With the exception; if you have surgery we will file your insurance. You are responsible for your calendar year deductible and whatever your insurance will not cover. You need to provide us with a completed claim form BEFORE we can file your insurance.

For our Medicare patients: We will be happy to file your insurance claim to Medicare for you. You are responsible for your deductible, 20%, and filing of your supplemental and/or secondary insurance.

I hereby authorize Southwest Retina Eye Center, Jose Mayans, M.D., or representatives thereof to provide information on behalf of myself and covered dependents as necessary to process health care claims on services provided. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date_____ Signature _____

Relationship to patient _____

907 West Second Street, Odessa, Texas 79763 (432) 333-1324
3001 W. Illinois, Ste. 3A, Midland, Texas 79701 (432) 689-2940
Toll Free Number 1 (800) 344-6116

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____ (printed name of patient or personal representative), acknowledge that **Southwest Retina Eye Center** has provided a written copy of its Notice of Privacy Practices for Protected Health Information to (check one) ☐ myself or ☐ specify: _____
(If signing as a personal representative, documentation of your legal right to do so must be provided.)

_____	__/__/20__	_____	_____
Signature of Patient or Personal Representative	Date (mm/dd/yyyy)	Printed Name	Relationship to Patient (if not self)

To be completed by Southwest Retina Eye Center

☐ We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____

_____	_____	_____	__/__/20__
Printed Name	Title	Signature	Date (mm/dd/yyyy)

Authorization To Disclose Protected Health Information

In order for Southwest Retina Eye Center to give any information regarding the patient we have to have written permission to disclose such information

This information includes the patient's medical condition, appointment dates and times, and/or any other information pertaining to the patient

This consent form does not pertain to our Medical Records release, you will need to fill out and sign our Medical Records Release Form.

Please fill out the form below-

_____Yes, I want my information released to:

Name - Relationship to Patient - Phone number

_____ No, I do not wish for anyone else to be able to get access to my medical records

_____ _____

Patient's Signature Date Signed

Consent to Use Protected Health Information

To provide for your healthcare, Southwest Retina Eye Center collects information about your medical history, physical examinations and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare may decide to obtain your consent to use personal health information for treatment, payment, or healthcare operations, but are not required to do so.

Therefore, I, _____ (printed name of patient or personal representative), consent that **Southwest Retina Eye Center** may use the health information of (check one) ☐ myself or ☐ (specify): _____ for the following purposes:
(If signing as a personal representative, documentation of your legal right to do so must be provided.)

1. Treatment (to perform actions required to help diagnose, maintain, or improve health);
2. Payment (to obtain reimbursement from third party payers);
3. Healthcare operations (to carry out, analyze, or improve business processes related to healthcare).

Southwest Retina Eye Center has privacy practices that are summarized in our Notice of Privacy Practices for Protected Health Information ("Notice"). This Notice describes the use and disclosure of protected health information, patients' rights relevant to examining medical records, requesting corrections and additions to these records, requesting restrictions to the use of health information, finding out to whom their protected health information has been disclosed, and registering any complaints relevant to privacy issues. The Notice also describes how to receive these rights. I have been provided with or have previously received a copy of this Notice and given the opportunity to review it prior to signing this consent. I understand that if I decide not to sign this consent, **Southwest Retina Eye Center** may decline to provide healthcare to me.

The consent I am signing today covers this and all future healthcare activities performed for me by **Southwest Retina Eye Center** with respect to treatment, payment, and operations. This consent replaces and supercedes any previous consents I may have signed with Southwest Retina Eye Center for such use of my healthcare information. If I wish to revoke this consent, such a request must made be in writing. However, a revocation does not cover actions that have already been taken in reliance upon the consent previously in force. In addition, I understand that if I revoke this consent, then **Southwest Retina Eye Center** may discontinue taking care of me.

Unless I object, my name, location, and general condition may be listed in a patient directory. Unless I object, my name and location may be disclosed to anyone asking for me by name. Unless I request otherwise, information about my health may be disclosed to other people involved in my healthcare (e.g., family members, personal representatives, those accompanying you for care). Unless I object, my religious affiliation may be disclosed to members of the clergy.

I have the right to request restrictions or limitations as to how my protected health information will be used to carry out treatment, payment, or healthcare operations. I understand that HIPAA does not require such requests to be accepted, but if restrictions are accepted, then they must be honored. I request the following restrictions to the use and/or disclosure of my health information: ☐ NONE or list below:

_____

_____	__/__/20__	_____	__/__/20__
Signature of Patient or Personal Representative	Date (mm/dd/yyyy)	Witness	Date (mm/dd/yyyy)

To be completed by Southwest Retina Eye Center

_____	_____	_____	__/__/20__
Printed Name	Title	Signature	Date (mm/dd/yyyy)

If restrictions are requested, an individual authorized to approve such restrictions must sign.