Dr. Lauren B. Guzik, OD
Independent Optometrist

PATIENT INFORMATION and CONSENT

Patient Full Name _____ **Birthdate** _____

Sex: M F **Gender: M F Other** **SSN**_____

Address _____

City _____ **State** _____ **Zip** _____

Home # _____**Cell #** _____ **Work #** _____

Email Address _____

Marital Status: ☐Single ☐Married/Partnered ☐Widowed ☐Divorced ☐ Separated

Employment Status: ☐Employed FT/PT ☐Retired ☐Not employed ☐Homemaker ☐Student

Employer or School: _____ **Occupation:**_____

Person responsible for payments on this account (*Name, Birthdate, Address – if other than patient*)**:**

_____

_____

PCP (Doctor's Name): _____ **Phone**_____

Address/City _____ **Fax #** _____

Primary Medical Insurance

Insurance Company _____

ID# _____ **Group #**_____

Primary Insured Name (*if other than patient)* _____**DOB**_____

Secondary Medical Insurance

Insurance Company _____

ID# _____ **Group #**_____

Primary Insured Name *(if other than patient* _____ **DOB**_____

Vision Benefit Plan

Company _____**ID#/Group#**_____

Dr. Guzik participates with most major medical plans and some Vision Benefit Plans. In many cases your medical plan will be billed first *(please see "Vision Discount Plans vs. Medical Insurance" for more information)*. If the reason for your visit is related to a medical diagnosis or a medical diagnosis is discovered during a "routine" eye exam and treatment is provided on the same day of service, then your medical insurance will be billed and medical specialist copay, co-insurance and/or deductible may apply. Insurance benefits and eligibility will be verified based on what information the insurance company has provided on-line. However, this is not a guarantee of coverage or payment and you are responsible for any balance due.
Fees may be added to your account for any delinquency including checks returned for insufficient funds or collection agency use to collect overdue payments. Also Dr. Guzik reserves the right to charge a $25 fee for missed appointments or cancellations with less than 24 hours notice. **Payment of copays and services not covered by your insurance are due at time of service.**

I hereby authorize Dr. Guzik to submit any claims necessary to my insurance company (or Medicare) on my behalf, and to release all information necessary to secure the payment of benefits for services rendered today and at subsequent visits and for those benefits to be paid directly to Dr. Guzik. I authorize the use of my signature below for all insurance submissions. I understand that I am financially responsible for all charges related to services rendered. I understand that it is my responsibility to know my benefits and to be aware of any copays, co-insurance or deductibles. I understand that any denied claims, co-insurance, copays or deductibles are determined by my insurance company and I will be responsible for any unpaid amounts as determined by my insurance contract(s).

Signature_____**Date**_____

Print Name *(if other than patient)* _____ **Relationship to patient** _____

Dr. Lauren B. Guzik, OD
Independent Optometrist

Consent to list or disclose health information for treatment, payment and health care operations and acknowledgement of receipt of the Notice of Privacy Practices.

Patient Name: _____ **Date of Birth**: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

We have a comprehensive *Notice of Privacy Practices* that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this *Consent Form.* As described in our *Notice of Privacy Practices,* the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices.* Our *Notice of Privacy Practices* will be updated whenever our privacy practices change.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our *Notice of Privacy Practices,* we are not obliged to *agree* to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read and understand this consent and acknowledge that I have received a copy of the Notice of Privacy Practices. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operation for as long as I am a patient of Dr. Guzik or until I request in writing that this authorization be revoked.

Patient/Parent/Guardian Signature: _____Date: _____

Name of Signer *(if not patient)***: _____**

Relationship to Patient: _____

Reviewed: _____

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