

Patient Information

Date _____

Name _____ Social Security # _____

Address _____ E-Mail _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Preferred number to contact: Home Cell Work

Male Female Birthdate _____ Age _____ Single Married Widowed Other

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

What is your reason for visit? _____

Name of emergency contact? _____ Relationship _____ Home Ph. _____
Work Ph. _____

Responsible Party Information

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____ Social Security # _____

Address (If different from Patient) _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone# _____

Insurance Company _____ ID# _____ Group# _____

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to all providers of the medical benefits, if any; otherwise payable to me for services rendered by Dr. Jared Powelson or Dr. Mike Gerstner.

I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any costs incurred in the collection of such account, including reasonable attorney fees and court costs. I hereby waive notice of dishonor, demand, and protest. All exemptions are waived.

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit and I am responsible for payment to Dr. Jared Powelson or Dr. Mike Gerstner for all services rendered the above patient that are not covered by Medicare assignment, Medicaid, Workman’s Compensation, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I authorize photocopies of this form to be valid as the original.

Patient or Guardian Signature _____ Date _____

Release of Medical Records and Information

To: Custodian of Medical Records

This authorized you to release to Midtown Eye Care, 16 N. McLean, Memphis, TN 38104 full and complete medial records, reports, evaluations, consultations or information (collectively referred to as “medical records”) you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all of the conditions recited herein.

The undersigned expressly releases and forever discharges and agrees to indemnify and hold harmless Midtown Eye Care, including its owner and employees, from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

Patient or Guardian Signature _____ Date _____

Acknowledgment of Privacy Policy

I acknowledge that I have viewed and been offered a copy of the privacy policy for Midtown Eye Care.

Patient or Guardian Signature _____ Date _____