Authorization for release of Information – Compound Release

Patient Name: _____ Acct #: _____

How would you like to receive information, such as appointment information, notifications about glasses/ contact lens orders, financial information, medical information and breach notification, etc. from Carolina Vision Associates? Please check the appropriate box and provide the email or phone number beside your choice.
(***Check each entity that you approve***)

Email: _____ _____
***** In order for email communication to occur, please accept the disclosure below by checking the box.*****
For email communication*, I understand that if information is not sent in an encrypted manner and there is a risk it could be accessed inappropriately, I still elect to move forward to allow email communication to occur.*

Text : Phone Number: _____

Phone Call: Phone Number: _____

I authorize Carolina Vision Associates to release my protected health information (including appointment information) to the below listed person/s. This person is also authorized to pick up glasses and/or contact lenses on behalf of the above named patient:
If the person/s listed below is also your emergency contact, please check the box in front of the name.

_____ _____ _____
Name of Authorized Person Relationship to Patient Phone Number

_____ _____ _____
Name of Authorized Person Relationship to Patient Phone Number

_____ _____ _____
Name of Authorized Person Relationship to Patient Phone Number

Patient Rights:
I have the right to revoke this authorization at any time.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
Information used or disclosed as a result of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.
I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Verification and Code: This practice will verify the identity of any entity requesting protected health information. Verification information may include the above relationship and listed phone number.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient or said expiration date.

_____ _____
Signature of Patient or Personal Representative Date of Signature

**Description of Personal Representative's Authority (attach necessary documentation) Exp. Date_____

CAROLINA VISION associates

FOCUSED ON YOU.

PATIENT REGISTRATION

Please review, make necessary changes and supply any missing information.

Patient Name				**Salutation**	
Birth Date		**Age**		**Birth State**	
Sex				**SS #**	
Address					
Address Type				**Country**	

COMMUNICATION					
Preference					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #					
Email					

Primary Language		**Special Needs**	
Race		**Ethnicity**	
Marital Status			
Occupation		**Employer**	

ACCOUNT RESPONSIBLE: **Patients >18, this will be the same information as the patient. Patients<18, this will be the parent or guardians information**					
Responsible				**Salutation**	
Relationship				**SS #**	
Address					
Home Phone #		**Work Phone #**		**Extension**	
Email					

PRIMARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

SECONDARY INSURANCE			
Name		**Group Name**	
D #		**Group #**	
Address			
Phone			

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ADDITIONAL INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone			

EMERGENCY CONTACT										
Sal	First	MI	Last	Relation	Home#	Cell#	Work#	Ext	Organization	Title

MEDICATIONS (use additional piece of paper as needed)

Added	Name	Dose	Form	Started	Stopped	Prescribed by	Use

ALLERGIES				
Allergy	Type	Onset	Reaction	Severity

MEDICAL HISTORY			
	Family Member	Relation	Yourself
Retinal Disease			
Other Disease			
Blindness			
Strabismus			
Amblyopia			
Diabetes			
Cancer			
Heart Disease			
Hypertension			
High Cholesterol			
Kidney Disease			
Stroke			
Other			
Glaucoma			
Cataracts			
ARMD			
Eye Injury			

DO YOU HAVE A HISTORY OF PROBLEMS WITH ANY OF THE FOLLOWING?:	
General Health	

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FOCUSED ON YOU.

DO YOU HAVE A HISTORY OF PROBLEMS WITH ANY OF THE FOLLOWING?:	
Cardiovascular	
Ears, Nose, Mouth, Throat	
Respiratory	
Gastrointestinal	
Genitourinary	
Musculoskeletal	
Integumentary	
Neurological	
Constitution	
Endocrine	
Hematologic/Lymphatic	
Allergic/Immunologic	
Other	

SURGICAL INFORMATION							
Date	**Eye**	**Pre-Op Dx**	**Post-Op Dx**	**Procedure**	**Surgeon**	**Op Notes**	**Complications**

SOCIAL HISTORY			
Have you ever had any problem with drug abuse?		**What Drug?**	
Do you drink Alcohol?		**How Much?**	
Do you smoke?		**Packs per day?**	

Do you work on a Computer?		**Hours Per Day**	

Do your eyes experience any of the following?:

O Burning	O Uncomfortable Glasses	O Floating Objects	O Glare or Reflection	O Soreness
O Sensitivity to Light	O Uncomfortable Contacts	O Blurry Distance Vision	O Strain/Headache	O Redness
O Excessive Tearing	O Double Vision	O Blurry Near Vision	O Gritty Feeling	O Dryness
O Difficulty Seeing at Night	O Flashes of Light	O Sudden Loss of Vision	O Itchiness	O Other

Patient Signature: _____

CAROLINA VISION associates

FOCUSED ON YOU.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of the Notice of Privacy Practices from Carolina Vision Associates in all locations.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____

Signature of Patient Date

_____

Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CAROLINA VISION associates

FOCUSED ON YOU.

New patient consent for treatment, payment, healthcare operations, coordination of care practices, and assignment of benefits to physician

Patient Name: _____ Date: _____

I understand that as part of my health care, Carolina Vision Associates originates and maintains paper and/or electronic records describing my personal and family health history, symptoms, examination and test results, diagnosis, treatment, demographic information, insurance information, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
  Please note that we make phone calls to remind you of scheduled appointments, and we may leave a message for you on answering equipment at your home.
- A means of communication among the many health professionals who contribute to my care,
  Please note that we may phone, fax, or e-prescribe orders for you to your local pharmacy or optical goods provider.
- A source of information for applying my diagnosis, treatments, and any surgical information to my bill,
- A means by which a third-party payer (insurance companies, etc.) can verify that the services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals, and
- A means of providing other healthcare professionals involved in the provision of my healthcare the information needed to coordinate my care.

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to my physician provider for services rendered to me. My attending physician in this practice is (circle one):

Dr. M. Fern Powell Dr. W. Michael Younger Dr. Richard D. Sprouse

Dr. Malissa T. Mathis Dr. Stephanie L. Younger

Dr. Rachelle R. Penka

I further authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and/or other insurance administrators any information needed to determine these benefits or the benefits payable for related services

I also authorize the release of any medical records from any health care provider to this physician for the purpose of providing coordinated healthcare services to me. And I authorize the release of any medical records from this physician to any healthcare provider for the coordination of my medical care.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

Because your appointment time is scheduled specifically for you, we would like to remind you that should you be unable to keep your scheduled appointment, and not call greater than 24 hours in advance of your scheduled appointment to cancel, a $75 no show fee will be assessed to your account.