

Child and Family Eye Care

Dr. Trafis Moffatt O.D. Dr. Troy Wagner O.D.

New Patients: How did you hear about our office? (circle one)

- Saw office driving by Interfaith Ad Facebook Insurance YouTube Twitter Website
 Dr.'s Office _____ Friend Referral _____
 Internet search engine ex. Google Places, etc. _____
 Other _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND PRACTICE

I understand that an attempt to protect the privacy of my identifiable information, Child and Family Eye Care of The Woodlands and Magnolia, Texas has established a Privacy Policy and guidelines for the Privacy Practices within their office. This information details the use and/or disclosure of the information contained in my personal medical/optometric record kept for the purposes of diagnosis, treatment, and health care operations. In accordance with HIPAA regulations, a copy of Child and Family Eye Care's Privacy and Practice has been made available to me while in the office today.

Print Patient Name: _____ Birthdate: _____

Signature: _____ Date: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the providing physician of any vision/medical benefits. If any, otherwise payable to me for his/her services. I understand that I am financially responsible for charges not covered by my insurance.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the providing physician to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company.

Signature: _____ Date: _____

INSURANCE INFORMATION

MAJOR MEDICAL: _____ VISION COVERAGE: _____

SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____

Date of Birth: _____ Date of Birth: _____

Identification #: _____ Identification #: _____

Social Security #: _____ Social Security #: _____

Group #: _____ Group #: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____