ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Sarah C Katie Parker, OD O.D.,

Notice of Privacy Practices. Date _____

Patient name_____ Signature _____

PARKER EYE CARE

A MEMBER OF VISION SOURCE

S. KATIE PARKER O.D.

Please complete to comply with meaningful use to improve the U.S. healthcare system.

Patient Full Name: _____ Date: _____

Address: _____

City, State, Zip: _____ Home Phone#: _____

Work Phone#: _____ Cell Phone#: _____

Male/Female: _____ Date of Birth: _____

Social Security #: _____ Marital Status: _____

Place of Employment: _____ Occupation: _____

Employment Status: Full time/Part time _____

Height: _____ Weight: _____

Tobacco Use: Yes or No

Alcohol Use: Yes or No

Please check the appropriate answer in each section:

Preferred language:
_____English
_____Spanish

Race:
_____American Indian or Alaska Native
_____Asian
_____Black or African American
_____Hispanic
_____Native Hawaiian or Pacific Islander
_____White

Ethnicity:
_____Hispanic or Latino
_____Native Hawaiian/Other Pacific Island
_____Non-Hispanic or Latino

Communication Preference: Email Postal Telephone Text

Email: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

258 Lakota Drive • PO Box 1470 • Cadiz, KY 42211 • Phone 270-206-9067 • Fax 270-206-9205

PARKER EYE CARE

A MEMBER OF VISION SOURCE

S. KATIE PARKER O.D.

Authorization for Medical and Vision Treatment

I authorize Dr. Sarah Katie Parker to conduct and direct my optometric care while I am a patient of Dr. Sarah Katie Parker, O. D. I also authorize staff, directed by my optometrist, to give medications, perform diagnostic procedures and provide other care which, in the judgment of my optometrist, is required for my best care and treatment.

Assignment of Benefits

I request that assignment of benefits of authorized Medicare, Medicaid, or Private insurance benefits be made to Parker Eye Care for any services furnished by Parker Eye Care when the doctor elects to accept assignment. I authorize any holder of medical or other information about me to be released if needed to determine these benefits to the Health Care Financing Administration or Centers for Medicare or Medicaid or other Private insurance companies.

Refraction

Refraction is the test for an eyeglass or contact lens prescription. This test may not be a covered service by your Private insurance company and never is covered by Medicare.

"I fully understand that the refraction part of my visit may not be covered by my private insurance and never is covered by Medicare and that if performed, the charge for this test will be my responsibility.

I understand that my Private insurance company may not pay for this service and Medicare does not pay for this service that I am about to receive, and I elect to have this service performed if that doctor thinks it's necessary to perform this service."

Signature_____ Date_____

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PARKER EYE CARE

A MEMBER OF VISION SOURCE

S. KATIE PARKER O.D.

In compliance with the 1996 HIPAA Privacy Regulations, our office strives to make every effort to protect your personal demographic and health information. The HIPPA regulations state that information regarding your health records and personal information may not be released without your consent.

Please list below any person(s) that you approve for your information to be released to. This will not allow the person(s) that you approve for your information, including, but not limited to billing/insurance, appointments, diagnosis, and treatments that you have discussed with your physician. You may list as many persons as needed or may request that your information not be released to any individual. Should you decide that no one be listed, we may not be able to answer any questions regarding your care with anyone other than yourself.

Information needed to process your insurance claims and refill any prescriptions will be covered under the standard HIPPA Compliance Act of 1996.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Patient Signature	Date

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