

Welcome to North Star Vision _____ Optometrists: Robert D. Strohl,
O.D.

Today's date: _____
O.D., PhD.

Michael J. Earley,

Patient Information

Last Name _____ First Name _____ MI _____ SS#

Address _____ Phone #s (please list all, mark the ones
that we can call):

City _____ State _____ ZIP _____ Home Phone

Date of Birth _____ Male ___ Female ___ Cell Phone

Marital Status: Single ___ Married ___ Other ___ Work Phone

Employed ___ Retired ___ Full Time Student ___ Part Time Student _____

Occupation

Employer* _____ * (this is a required field if you are
employed)

Address _____ Phone

Primary Care Physician _____ Phone

How did you hear about us?

Previous patient _____ Another office _____ Insurance _____ Yellow Pages

Internet ___ Sign ___ Advertisement ___ Friend/Co-worker

Emergency Contact Person

Name _____ Relationship _____

Phone # 1. _____ 2. _____

Billing and Insurance Information

Person responsible for payment (please print) _____ Phone # _____

SS# _____ Date of Birth _____ Employed by _____ Relationship to patient _____

We will make copies of all your insurance cards, both vision and medical, and keep them in your personal file. They will be updated annually. If your insurance changes you need to inform us. If you have secondary vision or medical insurance, please inform us and provide us with a card to copy. We will help you to coordinate benefits if we can. **IF** your insurance requires a referral to an eye doctor from your primary- care physician, you must furnish the correct referral form at the time of service.

Payments, Co-pays and Deductibles are Due at Time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductibles at the time of service. There will be a \$35.00 fee for any check returned to us by the bank for NSF.

Responsible Party (signature) _____ Date _____

1.

Assignment of Insurance Benefits; Medical/Personal Information

I assign directly to this office (North Star Vision @ Olentangy) all insurance benefits otherwise payable to me for services rendered. I understand that this authorization is a direct assignment of my rights and benefits under my policy. I agree to be responsible for all fees not covered, or denied, by my insurance be it vision and/or medical. I also authorize the release of any medical or incidental information acquired in the course of my examination or treatment to process insurance claims or further treatment to a referred doctor, per HIPAA regulations. If my insurance requires a referral from my primary-care physician and I do not provide that at the time of service I understand that I will be responsible for payment if my insurance company refuses my claim.

Person Responsible/Insured _____ Date _____

Relationship to Patient _____

Notice of Privacy Practices: HIPAA

I have been given the opportunity to review this office's Notice of Privacy Practices, which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. As a patient I have the right to request a restriction on the release of my information but I do understand that the law does not require North Star Vision to agree to those restrictions. I also know this office reserves the right to change the terms of its Notice, and to make changes regarding all protected health information controlled by them. I understand I can obtain this office's current Notice on request.

By signing this form, you consent to this office's use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this agreement, in writing, signed and dated by you. This will not affect any disclosures that have already been made by this office.

Person Responsible _____ Date _____

Relationship to Patient _____

Patient Name (if not "self") _____