# WELCOME TO OUR OFFICE

Appointment Date_____

Patient's name (please print)_____

If a child, parent's name_____

Street Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____Cell_____
May We leave a Message at these numbers? Yes or No

E-Mail Address_____May we contact you by email? Yes or No

Birth Date_____ M or F_____SSN_____

Employer_____Occupation_____

Spouse's Employer_____Work Phone_____

Health Insurance Carrier_____Policy#_____

Medicare/Medicaid #_____

Other Insurance Coverage_____Policy#_____

How did you find out about our office?_____

Whom may we speak to about your health care?_____

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I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered. I authorize this office to file insurance on my behalf.

Signauture_____ Date_____

Dr. Ralph Maynard, III OD PA

# CONSENT FOR USE OR DISCLOSURE OF INFORMATION

# FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (HIPPA)

I consent to the use or disclosure of my identifiable health information by Dr. Maynard in order to carry out treatment, payment or health care operations. I have been given the opportunity to review this office's Notice of Privacy Practices for a more complete description of potential uses and disclosures of such information.

At any time I retain the right to revoke this consent. Such revocation must be submitted to Dr. Maynard in writing. The revocation shall be effective as of the date signed. *Dr. Maynard may refuse to treat you, if you do not sign the Consent Form.* (except to the extent the facility is required to treat individuals by law.)

CORRESPONDENCE CONSENT: I AUTHORIZE THE OFFICE STAFF TO:

Leave a message on my answering machine/voicemail at home ___yes ___no #_____

Leave a message or text on my cell phone? ___yes ___no #_____

Send me an email at _____ ___yes ___no

Leave a message at my place of employment? ___yes ___no #_____

Discuss my medical condition with a family member or friend? ___yes ___no

If yes, please print name_____ relationship_____

I have read and understand this information. I am the patient or authorized person for patient to sign this document verifying consent to the above statement.

_____ DOB _____ date _____

Signature of patient or authorized person

## CONSENT FOR TREATMENT OF MINOR (UNDER 18)

I_____, give my consent for my child_____

To bring herself/himself to the office for treatment as necessary. This consent shall be effective at the date of my signing.

Parent signature_____ date_____

Witness_____ date_____