Today's Date: _____/_____/______

PATIENT INFORMATION

Patient Name: ____
Last First MI

Date of Birth: _____/_____/______ **Social Security Number:** ________________________ **Gender**: [ ] **M** [ ]**F**

Language (**circle one):** English / Spanish / French / Other __________________ **Race** (**circle one**): African American, Caucasian (white), Hispanic/Latino, Asian, Native American/Alaskan Native, Native Hawaiian/Pacific Islander

Marital Status (**circle one**): Single / Married / Separated / Divorced / Widowed

Mailing Address: ____
Street Apt# City/State/Zip Code

Phone Number: (____) ____________________ (____) ____________________ (____) ____________________
Home Cell Work

Email Address: ____

Primary Care Physician: _________________________ **Referred By (if applicable)**: ________________________

Pharmacy: ____ **Location/City**: _________________________

(To be completed if patient is under the age of 18 or has a Power of Attorney (POA))

Legal Guardian's Name: ____
Last First

Date of Birth: _____/______/_________ **Patient's Current School**: ______________________________________

Mailing Address (if different than patient): ____
Street Apt# City/State/Zip Code

Phone Number: (____) ____________________ (____) ____________________ (____) __________________
Home Cell Work

Social Security Number: ___________________________ **Relationship:** ________________________________

Authorization for disclosure of Personal Health Information

Our Notice of Privacy Practices, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides information about how we may use and disclose your protected health information. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- This practice has a õNotice of Privacy Practicesö and that the patient has had the opportunity to review this notice.
- The patient has the right to restrict the uses of their information, but this practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing, at any time and all future disclosures will then cease.
- This practice may condition treatment upon the execution of this consent.
- Benjamin L. Mackey MD is a Co-Owner/Share Holder of the Baptist Health Cumberland Valley Surgical Center at 275 KY-770, Corbin, KY 40701 and will perform most out of office procedures at that location.

The information contained within this document is true to the best of my knowledge. I understand that I am responsible for charges not covered by my health insurance including deductibles and co-pays. I hereby authorize Mackey Vision Center to release any information to my insurance carrier, a licensed physician, or other covered medical entity concerning my illness and treatment. I authorize payment by my insurance to Benjamin Mackey MD and/or Mackey Vision Center, PSC. I also acknowledge that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature:____ **Date:** __________________

Responsible Party (If other than the Patient)**:** ____________________________________ **Date:**_____________

Disclosure of Personal Health Information

(Please check one)
[ ] I do ***NOT*** authorize any other person to obtain my medical information.

[ ] It is ***OKAY*** to disclose/discuss my medical information with the following:

Emergency Contact: ____ Relationship: __________________

Phone Number: (______) ___________________________

Additional Contacts other than the Emergency Contact:

Family Member or Friend: ________________________________ Phone Number: (____) ___________________

Detailed messages regarding test results and appointment reminders can be left on answering machine or voice mail.

(Please check one)

[ ] No [ ] Yes (please provide phone number) (_____) ____________________

INSURANCE INFORMATION

Please give insurance cards and photo ID to receptionist so s/he can make copies.

Name of Insurance Company (**Primary**): ___________________________________ ID: ______________________

Name of Policy Holder (if different than patient): ____________________________ Relationship:_______________

Name of Insurance Company (**Secondary**): _________________________________ ID: ______________________
Name of Policy Holder (if different than patient): ____________________________ Relationship:_______________

Name of Insurance Company (**Vision**): ______________________________________ID: _______________________
Name of Policy Holder (if different than patient): ____________________________ Relationship:_______________

If this visit is due to an automobile accident or workers compensation case, please fill out the following:

Date of accident or injury: ____/____/______ Employer (if applicable):___________________________________

Insurance Company ____ Claim #:___________________________

Contact Person: ____ Phone: (_____)______________________