PATIENT INFORMATION

NAME _____
ADDRESS_____
CITY_____STATE _____ZIP_____
HOME PHONE: _____ CELL:_____
DATE OF BIRTH_____AGE_____SEX _____
EMAIL: _____

PRIMARY INSURANCE: _____ ID#_____
SECONDARY INSURANCE:_____ID#_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____
HOME PHONE:_____CELL:_____

PRIMARY CARE PHYSICIAN**:**NAME:_____PHONE: _____

MEDICATIONS:

_____
_____

ALLERGIES TO ANY MEDICATIONS:

_____

PHARMACY:

_____

INSURANCE AUTHORIZATION & RELEASE:

I authorize John Schofield, D.O., to bill my health insurance and to receive all payments directly for services rendered. I will be held responsible for all deductibles and copays, which are determined by the individual carrier. I authorize the release of my benefits and eligibility to John K. Schofield, D.O.

_____ _____
PATIENT SIGNATURE (or responsible party) DATE

John K. Schofield, D.O. Eye Physician & Surgeon
Glaucoma Specialist
3 Locations to Serve You
Beverly Hills, Palm Desert & Lancaster

NOTICE OF PRIVACY PRACTICE-PATIENT ACKNOWEDGEMENT:

I have been presented with a copy of this provider's Notice of Privacy Practice, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the notice and I request the following restrictions concerning my personal medical information:

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I understand that as part of my healthcare, John K. Schofield, D.O. Ophthalmic Surgeon, Inc., originates and maintains paper and/or electronic records describing my health history, symptoms, examination, diagnosis, treatment and any plans for future care or treatment. I understand this serves as:

- A basis for planning my case and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that such services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with the Notice of Privacy Practice Policies, a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purpose and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I authorize John K. Schofield, D.O. Ophthalmic Surgeon, INC. to disclose my health information to another physician as part of my treatment. Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to John K. Schofield, D.O. Regulations pertaining to medical assignment of benefits apply. I fully understand and ACCEPT the terms of this consent.

_____ _____

PATIENT SIGNATURE (or responsible party) DATE