BLACK HILLS REGIONAL EYE INSTITUTE

Account #_____ Provider_____

How were you referred to us?_____

PATIENT INFORMATION (PLEASE PRINT)

PATIENT NAME (LAST, FIRST, MI)	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER
MAILING ADDRESS	CITY AND STATE	ZIP CODE	PHONE NUMBER
			HOME:
May we leave a message regarding medical care or appointments? YES NO			CELL:

RESPONSIBLE PARTY

THE RESPONSIBLE PARTY LISTED BELOW WILL BE FINANCIALLY RESPONSIBLE FOR THE ACCOUNT. THEIR SIGNATURE IS REQUIRED PRIOR TO APPOINTMENT.

SIGNATURE_____ DATE_____

RESPONSIBLE PARTY (LAST, FIRST, MI)	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER
MAILING ADDRESS	CITY AND STATE	ZIP CODE	PHONE NUMBER
			HOME:
EMAIL ADDRESS:			CELL:

EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

SPOUSE'S NAME (LAST, FIRST, MI)	DATE OF BIRTH	SEX	CELL NUMBER

SPOUSE'S EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

EMERGENCY CONTACT

NAME (LAST, FIRST, MI)	HOME PHONE NUMBER	CELL PHONE NUMBER
ADDRESS		WORK PHONE NUMBER

HIPAA RELEASE--Authorization for the Use and Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Black Hills Regional Eye Institute, LLP, Black Hills Regional Eye Surgery Center, LLC, and Black Hills Regional Eye Refractive Surgery Center, LLC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures to the individuals indicated below. You may revoke this authorization at any time by signing and dating a revocation form and returning it to this office.

NAME	NAME	NAME

SIGNATURE_____ DATE_____

INSURANCE INFORMATION

IS A MANAGED CARE PROVIDER or PCP REFERAL REQUIRED FOR ANY OF YOUR COVERAGE? YES NO

WHO IS YOUR MANAGED CARE PROVIDER or PCP?

PRIMARY INSURANCE	**SECONDARY INSURANC**	**TERTIARY INSURANCE**
POLICY NUMBER	POLICY NUMBER	POLICY NUMBER
GROUP NUMBER	GROUP NUMBER	GROUP NUMBER
EFFECTIVE DATE	EFFECTIVE DATE	EFFECTIVE DATE
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S DATE OF BIRTH
SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S EMPLOYER

ASSIGNMENT OF BENEFITS--RELEASE OF INFORMATION

I request that payment of authorized Medicare or other insurance carrier benefits be made either to me or on my behalf to the Black Hills Regional Eye Institute, Eye Surgery Center, or Anesthesia Services for any services furnished me by the physicians at the Institute. I authorize any holder of medical information about me to release to the Health Care Finance Administration (Medicare) or any other insurance carriers that I have contracted with or their agents, any information needed to determine those benefits or the benefits payable for related services. I have received a copy of the Notice of Medical Information Privacy Right for the Black Hills Regional Eye Institute, LLP, Black Hills Regional Eye Surgery Center, LLC, and Black Hills Regional Refractive Eye Surgery Center, LLC.

SIGNATURE_____ DATE_____