FAMILY VISION CARE
MARIA A. STANLEY, O.D. INC.

Welcome to our office! It is our objective to provide you with the finest vision care possible.
We appreciate having you as our patient.

Today's Date:____________________________________
Patient's Name:___________________________________ Date of Birth:______________________
Circle One: Mr. Mrs. Ms. Miss. Dr. Rev. Age:_____________________________
Name you would like our staff to call you:____
Mailing Address:____
City:________________________________ Zip Code:______________________________________
Occupation:___________________________ Employer:_______________________________________
Home Phone:__________________________ Work Phone:____________________________________
Patient's Social Security Number:____
If a minor: Parent's Names:____
Spouses Name:____
Referred by:____

PAYMENT ON FEES IS EXPECTED AS SERVICES ARE RENDERED.

Who is responsible for payment of this account?____
Member's Social Security Number:____
Medical Insurance Co:____
Vision Insurance Co:____

Receipt of Notice of Privacy Policies & Consent Form:

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. Medical records will be retained for a period of 5 years. If the patient is under the age of 18, the records will be retained for a period of 5 years commencing with the first date of treatment following the patient's 18th birthday. The ***Notice of Privacy Practices*** you have been given describes the uses and disclosures in detail.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. We are allowed to refuse to treat you if you do not sign the consent form. Your signature also signifies that you have received a copy of our ***Notice of Privacy Practices***.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Maria A. Stanley, O.D. Inc.

____ ________________________
Signature/ Relationship to Patient Date