Dr. Tom MacMillan
Dr. Jeremy Anderson
Dr. David MacDonald
Dr. Lindsay Wood

Spartanburg VISION

1200 E. Main Street, Suite 2
Spartanburg, SC 29307
(864) 585-7807
www.spartanburgvision.com

*Our **vision** is to protect **yours***

Date: ____ / ____ / ____

Name: Last _____ First _____ M.I. _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home / Mobile Phone: _____ Texting Okay? Y / N Work Phone: _____

Date of Birth: _____ / _____ / _____ Age _____ Male / Female SS#: _____

Employer: _____ Occupation: _____ Email: _____

Name of Primary **Medical** Insurance Carrier: _____ ID #_____

Name of Secondary **Medical** Insurance Carrier: _____ ID # _____

Name of **Vision** Insurance Carrier: _____ ID # _____

~ You will be responsible for any portion of your bill which is not paid for by your insurance company.~

Authorization for Release of Information

This form authorizes Spartanburg Vision to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mails/answering machine messages.

I consent to the release of (please check all that apply):

- ☐ Financial/Billing Information
- ☐ Medical Care (treatments plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:

- ☐ Patient's voice mail/answering machine
- ☐ Voice mail/answering machine of (e.g. spouse, parent sibling):

_____ _____
Name/Relationship to patient Phone

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Spartanburg Vision. I understand that a revocation is not effective in cases where the information has already been disclosed.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

X_____
Signature of Patient (parent or legal guardian if minor)

Notice of Privacy Practices

Spartanburg Vision will provide me a copy of their Notice of Privacy Practices upon request. _____
(Please Initial)

Statement of Financial Responsibility and Assignment of Insurance Benefits

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Spartanburg Vision.

X_____ _____ _____
Signature of Patient (legal guardian if minor) Print Name Date