EYEDIOLOGY
VISION CARE

Welcome Form

Dr. Jennifer Burke O.D & Dr. Rory Murphy O.D
4175 S. Grand Canyon Drive #105 Las Vegas NV 89147
P: 702-912-4254 / **F:** 702-847-7624 / **E:** concierge@eyediologyvisioncare.com

Full Name:			**Preferred Name:**
DOB:	**SSN:**	**Marital Status:**	**Gender:**
Cell Phone Number:		**E-mail:**	
Address:	**Apartment #:**	**City/State:**	**Zip:**
Employer:		**Occupation:**	
Primary Medical Insurance:	**Policy Holder Name:**		**DOB & last 4 of SS#:**
Secondary Medical Insurance:	**Policy Holders Name:**		**DOB /last 4 of SS#:**
Primary Care Physician Name:		**Primary Care Phone Number:**	
Preferred pharmacy:		**Cross Streets:**	
How did you hear about us?			
Race: American Indian/ Alaska Native	Asian	Black/African American	Hawaiian/Pacific Islander White Other
Ethnicity: Hispanic/Latino	Not Hispanic/Latino	**Preferred Language:**	

Please give ALL MEDICAL & VISION INSURANCE to the Concierge
Send electronice insurance cards to us via text message to 702-912-4254

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Acknowledgement of Policies:

HIPPA Privacy Policy: I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Eyediology Vision Care can use and disclose my personal health information both with and without my written authorization for medical purposes. I also understand that a written authorization must be signed by me for release of my personal health information to a designated family member or friend.

Financial Policy: I authorize Eyediology Vision Care to bill my insurance for the services I received. I understand that I am financially responsible for charges that are not covered by my insurance.

Return Policy: I have read and understood the Eyediology Vision Care return policy.

Patient Portal: I have been given access to the Eyediology Vision Care Patient Portal. I acknowledge that I have access to my personal health information and my prescriptions through electronic means.

Contact Lens Prescription: If I elect to get contact lenses, I have read the Contact Lens Prescription Acknowledgement and I will receive a copy of my prescription at the completion of my fitting by:

☐ **Written printed Prescription** ☐ **Electronic Rx through my Patient Portal**

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the above policies. I acknowledge that the information provided to Eyediology Vision Care is up to date and accurate. I further understand that I may contact Eyediology Vision Care if I have any questions or concerns regarding the contents of this acknowledgment

_____ _____

Patient Name: **Date:**

_____

Signature

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Authorization to Release Protected Health Information

The communication of healthcare information plays an essential role in ensuring that individuals receive prompt and effective care. Eyediology Vision Care understands there may be times when a patient will need to have their family members call to request prescriptions, encounter notes, and financial information. Under the requirements of the HIPAA Privacy Rule we are not allowed to give this information to anyone without written authorization.

If you wish to have your medical information and/or financial information released to any family members you must give us written authorization by filling out the information below.

I _____ , authorize **Eyediology Vision Care** to disclose
(Print Your Name)

Please select One:

☐ Prescription Only

☐ Only notes from _____(date) to _____(date)

☐ All my health & Financial information

Eyediology Vision Care may disclose my health information to the following family member
(please print)

Name:_____ **Date of Birth:**_____

Relation to Patient:_____ **Phone Number:** _____

Email address:_____
This authorization will expire 2 years from the date of signature unless otherwise specified with an expiration date.

_____ _____
Print Name **Date**

_____ _____
Signature **Expiration Date (optional)**

Eyediology Vision Care – Grand Canyon
Dr. Jennifer Burke & Dr. Rory Murphy
4175 S. Grand Canyon Dr. Ste #105
Las Vegas, NV 89147
P: (702) 912-4254 / F: (702) 847-7624

Authorization for Medical Release of Records

Patient: _____ **DOB:**_____

I hereby authorize the release of my medical records/prescriptions from:

Office/Doctor Name: _____

Address: _____

Phone & Fax: **P:**_____ **F:**_____

Date Range: _____

To: **Eyediology Vision Care Grand Canyon**
4175 S. Grand Canyon Dr.
Las Vegas, NV 89147
P: (702) 912-4254 / F: (702) 847-7624
Email: concierge@eyediologyvisioncare.com

_____ _____
Signature: **Date:**

_____
Parent Name (if minor)