# WELCOME to the PALOUSE OCULARIUM ~ Dr. William French, Optometrist

To better serve you, we request the following information.
Information will be held in confidence.

Full Name: ______________________ Date of Birth: __________ Age: ____
Name you go by: ______________________ Social Security Number: __________
Local Address: ______________________ Phone: __________
Permanent Address: ______________________ Phone: __________
Hobbies/Interests: ______________________ E-mail: __________

Occupation: __________ Employer: __________ Phone: __________
In case of emergency, contact: __________ Relationship: __________
Contact person's address: ______________________ Phone: __________

If child, parents' name: ______________________ Phone: __________
If child, parents' employer: ______________________ Phone: __________
Person responsible for payment of account: ______________________
Address: ______________________ City, State, Zip: __________

Marital Status (please circle one): Single / Married / Widowed / Divorced
Student Status (please circle one): non-student / Full-time / Part-time
Names and ages of others in your immediate family: ______________________

Are there any specific concerns or questions that you would like us to address today? ______________________

What influenced you to choose our office?

Referral ____ Who may we thank for referring you? ______________________

Location ____, Coupon ____, Services ____, Hours ____, Other __________

Yellow Pages Ad:
- ____ Hagadone Phone Book (the Black Book)
- ____ Insight Directories (the smaller phone book)
- ____ UI Campus Directory (the Blue Key Directory)
- ____ Verizon (GTE) Yellow Pages
- ____ WSU Campus Directory

Which of the above phone books do you prefer to use? ______________________

FEES are payable when services are rendered. This is not a reflection of your credit, but of our effort to run an economically efficient office. We are happy to file claims to most insurance companies for you. Please let us know if you have insurance.

"I am aware that I am responsible for payment of all services rendered to me or my dependents regardless of whether or not insurance is involved. I authorize release of medical/other information to my insurer(s)(if any), including Medicare and Medigap, and authorize payment of benefits to Dr. French for services rendered through his office."

Signed, ______________________ Date: __________

We frequently communicate with our patients via e-mail. May we have your permission to send the following correspondence via e-mail?

| | Yes | No |
|---|---|---|
| Personal communication for you specifically | ____ | ____ |
| Our periodic newsletter | ____ | ____ |
| Notices about new products and special offers | ____ | ____ |

Your privacy matters to us. We will not sell or release your e-mail to anyone.

If you are 18 years old or older and are depending on parents/guardians for insurance or payment of your account, may we have permission to discuss your account and results of your examinations with them? Yes No Initial ___

THANK YOU for choosing the Palouse Ocularium. We're glad you're here!

# Receipt of Notice of Privacy Policies & Consent Form

**Palouse Ocularium/Dr. William R. French, Optometrist**
**202 E 7th St, Moscow, ID 83843-3002**
**208-883-EYES (3937) or 800-549-3792**
**Fax: 208-883-3211 E-mail: dfrench@moscow.com**

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Patient Name: ______________________________________________

Patient Address, City, State, Zip Code: ______________________________

Patient Phone Number: ________________________________________

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.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment: (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment: (3) our submission of your health information to auditors hired by third-party payers and insurers: and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

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. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

**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 Palouse Ocularium/Dr. William R. French.**

______________________________________________ ____________________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________________ ______________________________
Relationship to Patient Print Name

Source of Authority: __________________________________________