Lally Vision Care

Steven Lally, O.D. Tron Lally, O.D.

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Lee's Summit, MO 64064
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www.LallyVisionCare.com

Patient Information

Name: First _____ MI_____ Last_____ Today's Date_____/_____/_____

Address_____ City_____ State_____ Zip_____

Birthdate_____/_____/_____ Social Security # _____-_____-_____ ☐ Male ☐ Female

Phone Numbers: Home (_____)_____-_____ Mobile (_____)_____-_____

Work (_____)_____-_____ E-mail _____

Do you have a preferred way for us to contact you during the day? ☐ Home ☐ Mobile ☐ Work

If a minor or married, please list parents or spouses name to contact_____

Occupation _____ Employer _____ Name of Medical Doctor_____

Student ☐ Yes ☐ No School_____ Major_____ Hobbies / Sports _____

Who may we thank for referring you to our office? ☐ Family ☐ Friend ☐ Internet ☐ Insurance ☐ Name _____

Marital Status_____ **Preferred language:** ☐ English ☐ Other _____ **Ethnicity:** ☐ Hispanic ☐ Not Hispanic

Race: ☐ White / Caucasian ☐ Black / African American ☐ Asian ☐ American Indian ☐ Hawaiian / Pacific Islander

Insurance

Medical Ins. Co._____

Vision Ins. Co._____

Policy Holder (if other than the patient)_____ Date of birth of policy holder_____ Social Security # of policy holder_____

Preferred Pharmacy & Location_____

Do you participate in a Flexible or Health spending account? YES NO

Payment Information

I authorize and request my insurance company to pay directly to Lally Vision Care any health benefits resulting from care received in this facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and agree to assume responsibility for any services not covered. I consent to the release to my insurance company of any medical record necessary to resolve claims for services rendered. I understand that co-pays and any services not covered by an insurance company are due in full at time of service.

HIPAA PRIVACY PRACTICES CONSENT

As a condition of providing treatment to you, and by HIPAA rules our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of our office. You may revoke this consent at any time by notifying our office in writing, except to the extent that our office has already taken action. You have the right to request our office to restrict the manner in which your protected health information is used or disclosed. Also by HIPAA rules, our office is not required to agree to such requested restrictions; however we will do our best to comply with any such requests.

I hereby consent to the use and disclosure of my protected health information by Lally Vision Care, P.C., its staff, and its business associates for purposes of treatment, payment, and health care operations. I am aware I can request a copy of Lally Vision Care, P.C.'s HIPAA Compliant "Notice of Privacy Practices" and it will be provided.

By signing here, I agree to both the HIPAA Privacy Practices Consent and the Payment information above.

Signature_____ **Date**_____

Please turn over and complete the other side.