Last Name	_____	Date of Last Exam	_____
First Name	_____	By Whom	_____
Address	_____	Responsible Party	_____
City	_____	Date of Birth	_____ Age_____
State & Zip	_____	Occupation	_____
Home Phone	_____	Medicare/Medicaid #	_____
Cell Phone	_____	Social Security #	_____
Work Place	_____	Name on Insurance	_____
E-mail	_____	Insurance ID #	_____

Reason for Today's Exam _____

Please check any condition that applies to yourself or any members of your immediate family:

	Self	*Family*		*Self*	*Family*		*Self*	*Family*
Diabetes	____	____	Thyroid Problems	____	____	Double Vision	____	____
High Blood Pressure	____	____	Glaucoma	____	____	Blindness	____	____
Cataracts	____	____	Retinal Detachment	____	____	Head/Eye Injury	____	____
Heart Problems	____	____	Eye Surgery	____	____	Headaches	____	____
Respiratory Problems	____	____	Lazy Eye	____	____			

Medications you are currently taking _____

What allergies do you have, if any? _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

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. We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services 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 our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers or insurers, among 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 or from our website. 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 health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent. You have a right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated 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 CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Signature *Date*

I request that payment of authorized Medicare benefits be made on my behalf to me, for services furnished by Dr. Greg O'Bryan. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ _____

Signature *Date*