William F. Hoyer, OD

112 W. First Street Cloverdale, CA 95425

Office - 707-894-3936 Fax - 707-894-3998

Consent to use or disclose health information for treatment, payment and health care options.

Patient Name ____ Date of Birth___________

Address ____ City _________________

Phone Number________________________ Cell___________________________ Text Msg Y / N

Email ____

Insurance Carrier____ ID # ___________________

In the course or 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 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 of the ***Notice of Privacy Practices*** 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 health care operations. You can revoke this consent in writing at anytime 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.

You have the 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 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.

1. **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.**
2. **I authorize William F. Hoyer, OD to act as my agent in helping me obtain payments of my insurance and/or Medicare benefits. I authorize payments of these benefits directly to William F. Hoyer, OD on my behalf for any services and materials.**
3. **Please release my records to William F. Hoyer, OD located at 112 W First Street, Cloverdale, CA 95425.**

____ ______________________________

Patient Signature **Date**

If signing as a personal representative of the patient, please describe the relationship to the patient.

____ ______________________________

Print Name **Relationship to Patient**

Patient History Questionnaire

Patient Name____________________________________ Primary Care Physician_______________________

Last Eye Exam ___________________________________ Optometrist ________________________________

Do you have any problems with any of the following? Eyes Y / N

Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Integumentary	Y / N	Allergic/Immune	Y / N

Please explain: ____

____

Diabetes Y / N Type:___________________ Date of diagnosis _________________A1C_________

Allergies Y / N To what? ____

What happens? ____

Other Health Problems: ____

____

____

Current Medications: ____

____

____

Do you use Cigarettes/Tobacco? Y / N_____________ Alcohol Y / N_____________ Other Y / N ____________

Lifestyle: ____

FAMILY HISTORY:

High Blood Pressure Y / N Who? _____________________ Diabetes Y / N Who? ________________________

Macular Degeneration Y / N Who?____________________ Cataracts Y / N Who? _______________________

Retinal Detachment Y / N Who? ____________________ Glaucoma Y / N Who? _______________________

Other Eye Conditions Y / N Who? ____

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PERSONAL EYE INFORMATION:

Ave you had any eye operations? Y / N ____________________________________ Date ___________________

Have you had any eye injuries? Y / N ______________________________________ Date___________________

NOTES: ____

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