

Dr. Elizabeth M. Darby  
Optometrist, PLLC  
3701B Old Forest Road  
Lynchburg, Virginia 24501

\*\*\*\*\*PATIENT REGISTRATION\*\*\*\*\*

Name \_\_\_\_\_  
Social Security # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Marital Status (choose one) Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
911 Physical Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone ( ) \_\_\_\_\_

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Vision Insurance Company \_\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Relationship to Subscriber (choose one) Self \_\_\_\_\_ Spouse \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Primary Health Insurance Company \_\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Relationship to Subscriber (choose one) Self \_\_\_\_\_ Spouse \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Secondary Health Insurance Company \_\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Relationship to Subscriber (choose one) Self \_\_\_\_\_ Spouse \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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Emergency Contact \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

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NEW PATIENTS ONLY...Who may we thank for referring you to our office?

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

- Another Doctor      Doctor's Name \_\_\_\_\_
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages      Which Directory \_\_\_\_\_
- Web Page          Which Web Site \_\_\_\_\_
- Other              \_\_\_\_\_

\*\*\*\*\*PATIENT CONSENT\*\*\*\*\*

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As a patient of Dr. Elizabeth M. Darby, Optometrist PLLC we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we think are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

The release of information to other family members needs to be authorized in writing by the patient before disclosure of treatment results or health information is released. Dr. Elizabeth M. Darby, Optometrist PLLC will not be responsible for individuals posing as or impersonating someone else when requesting results via the phone.

We may at times have an indirect treatment relationship concerning you, for example, with laboratories that relay information directly to the physician and not the patients. These entities do not require a separate patient consent although personal health care information will need to be disclosed for appropriate care.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI), but this must be done in writing to the Privacy Officer, Dr. Elizabeth M. Darby, Optometrist PLLC, 3701B Old Forest Road, Lynchburg, Virginia, 24501.

Under this law, we have the right to refuse to treat you should you refuse to disclose your PHI. If you choose to give consent in this document, at some further time you may request to refuse all or part of your PHI from being disclosed. You may not revoke actions that have already been taken which relied on this or a previous signed consent.

A copy of Dr. Elizabeth M. Darby, Optometrist PLLC's privacy notice is available to review at all times during regular business hours.

I consent to the use or disclosure of my protected health or vision information by Dr. Elizabeth M. Darby, Optometrist PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Elizabeth M. Darby, Optometrist PLLC. I understand that diagnoses or treatment of me by Dr. Elizabeth M. Darby, Optometrist PLLC may be conditioned upon my consent as evidenced by my signature on this document. I also acknowledge my receipt of the Notice of Privacy Practices.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize the following persons to access to my health information:

- 1. \_\_\_\_\_ Relationship \_\_\_\_\_
- 2. \_\_\_\_\_ Relationship \_\_\_\_\_
- 3. \_\_\_\_\_ Relationship \_\_\_\_\_

\*\*\*\*\*INSURANCE ASSIGNMENT\*\*\*\*\*

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ (Name of Insurance Company(ies)) and assign directly to Dr. Elizabeth M. Darby, Optometrist PLLC all insurance benefits, if any, otherwise payable to me for services rendered. Please be advised that if you are using insurance coverage for your visit, this is a contract between you and your insurance company.....not our office. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Elizabeth M. Darby, Optometrist PLLC may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\*\*\*\*\*PAYMENT\*\*\*\*\*

I UNDERSTAND THAT PAYMENT IS EXPECTED ON THE DATE OF SERVICE (INCLUDING ALL CO-PAYS AND DEDUCTIBLES) UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

Signature \_\_\_\_\_

Date \_\_\_\_\_