PATIENT NAME	SOCIAL SECURITY NUMBER (at least last 4 digits)	BIRTHDATE

1. I have read the Harbor Ophthalmology PLLC Notice of Privacy Practices (HIPPA) and I acknowledge that I may request a copy for my records.

_____ _____
Patient's Signature Date

2. I give permission to Harbor Ophthalmology PLLC and their staff to leave appointment reminders and messages for a return call with the person who answers my phone or on my answering device.

I authorize _____ to obtain my medical information.
(list spouse, relative, friend or cross out this section)

_____ _____
Patient's Signature Date

3. I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Harbor Ophthalmology PLLC for services rendered. I request payment of government benefits to party who accepts assignment. I request payment of authorized MEDIGAP and secondary insurance benefits be made on my behalf to Harbor Ophthalmology PLLC for any services furnished to me.

_____ _____
Patient's Signature Date

4. I agree to pay all copayments, non-covered charges and deductibles at the time of service.

_____ _____
Patient's Signature Date