Piedmont Eye Associates

Yearly Update Sheet

Patient Information

Name:			Social Security Number:	
Email Address:			Home Phone:	Cell Phone:
Mailing Address:				
City:	State:	Zip:	Date of Birth:	Sex: M / F

Required Information

Marital Status (Circle One): Single Married Divorced	**Race (Circle One):** Asian African-American Caucasian Hispanic Indian Other:
Ethnicity (Circle One): Hispanic Non-Hispanic Decline	**Language (Circle One):** English Spanish French Russian Japanese Chinese Other:

Primary Care Physician: _____

Pharmacy Name and Location: _____

Emergency Contact

Name:	Relationship:
Home Phone:	Other Phone:

Preferred Method of Contact (Please write number under preferred contact method)

Home	**Cell**	**Other**
_____	_____	_____

Release

_____ (Initial) I **DO NOT** authorize any information to be disclosed to any other parties except to me as the patient.

_____ (Initial) I **authorize** the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Piedmont Eye Associates.

Name/Relationship:	Phone Number:
Name/Relationship:	Phone Number:

Patient Signature: _____ Date: _____

PER HIPAA REQUIREMENT, **THIS FORM MUST BE COMPLETED <u>ANNUALLY</u>.**

Piedmont Eye Associates

Authorization for Release
Use of Cell Phone, Email & Voicemail Communications

Name: Date of Birth:

Preferred Method of Contact

Please circle one and write the number on the line below:

Home Phone Mobile Phone Other

_____ _____ _____

_____ (Initials) **I grant consent for Piedmont Eye Associates to contact me via wireless telephone calls.** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify Piedmont Eye Associates to the contrary in writing.

_____ (Initials) **I grant consent for Piedmont Eye Associates to contact me via email.** If at any time I provide my email address at which I may be contacted, unless I notify Piedmont Eye Associates to the contrary in writing,

_____ (Initials) **I understand that cell phone, e-mail, and the use of voicemail communications are not secure forms of communication** and that confidentiality of any cell phone, e-mail, and voicemail information cannot be ensured.

**Certain providers in our practice do utilize Patient Portal, an online website where you can access your health information and communicate with our practice in a secure environment. Ask our front office staff if your provider is a participant in Patient Portal and how you can enroll. **

By signing below, I consent to receive communications, including but not restricted to billing and payment for items and services and communication from Piedmont Eye Associates, clinic, hospital, affiliates, contractors, servicers, clinical providers, attorneys, or its agents including collection agencies.

Patient or Patient Representative Signature: _____
Date: _____

PER HIPAA REQUIREMENT, **THIS FORM MUST BE COMPLETED <u>ANNUALLY</u>.**