Dr. Bethany Harrington O.D.
Dr. Marc Hautot O.D.
Dr. Bonnie Keaton O.D.

## CONFIDENTIAL PATIENT INFORMATION

Patient's Name:_______________________________________ DOB:___________ SS#________________________

Home # :_________________________________ Cell # :____________________________________

Email:___________________________________________________________________________________________

Home Address:____________________________________________________________________________________

**Primary Medical:**_________________________________ Policy #:______________________________________

Policy Holder's Name:_____________________________ Policy Holder's D.O.B.:_________________________

**Secondary Medical:**_______________________________ Policy #______________________________________

Policy Holder's Name:_____________________________ Policy Holder's D.O.B.:_________________________

**Vision Insurance:**________________________________ Policy Holder's SS#:____________________________

Emergency Contact Name and Number:_________________________________________________________________

Please list any names of people AUTHORIZED to your medical records:_____________________________________

## Patient HIPPA Consent:

In our office, we have our Notice of Privacy Practices published. This Notice contains a Patient Right's section describing your right under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at 601-795-0137. You have a right to request how protected health information about you is used or disclosed for your treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you at any time; however, that does not affect any disclosures we have already made in reliance with your prior consent. This content is required so that Poplarville Eye Clinic is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**Patient Signature:**_______________________________________________ **Date:**______________________