PEQUOT EYE CENTER
4461 Main Street
P.O. Box 176
Pequot Lakes, MN 56472
218-568-5555

CROSSLAKE EYE CENTER
35280 Cty. Rd. 3
P.O. Box 730
Crosslake, MN 56442
218-692-4700

Patient Registration Sheet:

Patient's Name: _____ Date: ___/___/_____

Address: _____ City:_____ State: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth ____/____/_____ Sex: M / F SSN: _____

Marital Status: Single Married Divorce Widowed Spouse Name: _____

Family Doctor: _____

Responsible Party if Minor: _____

Patient or Responsible Party's Employer: _____

Occupation: _____ City: _____ State:_____ Zip: _____

I authorize the release of any medical information necessary to process all claims and payment for medical benefits to my physician.

Patient's Signature: _____ Date: ____/____/_____

I request that payment of authorized Medicare benefits be made to me or on my behalf to Todd Wiedell OD, LLC for any services furnished to me by that physician/ clinic/ supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Medicare Patient's Signature: _____ Date: ____/____/_____

Notice of Privacy Practices Acknowledgment:

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my healthy information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____/_____/_____