

Name:

DOB:

Date:

CENTER FOR ADVANCED EYE CARE / ADVANCED EYE SURGERY CENTER

Ophthalmology • Ophthalmic Plastic & Reconstructive Surgery

Patient Privacy Questionnaire and HIPAA Acknowledgement

Name

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health-related matters.

May we contact you at home? ☐ yes ☐ no ☐ n/a Home ph

Is it okay for us to leave a voice message at this number? ☐ yes ☐ no

May we contact you at work? ☐ yes ☐ no ☐ n/a Work ph

Is it okay for us to leave a voice message at this number? ☐ yes ☐ no

May we contact you via mobile phone? ☐ yes ☐ no ☐ n/a Mobile ph

Is it okay to text message you about appointment reminders? ☐ yes ☐ no

May we contact you via email? ☐ yes ☐ no ☐ n/a Email :

Can a message be left with our company name and what the call is in reference to?

Is there anyone we may leave a message with? ☐ yes ☐ no If yes, please list first and last names.

Who do you authorize our staff to speak to regarding your medical information?

I give permission for my Eyeglasses/Contact Lens prescription to be available to me on my portal.

Would you like to authorize an individual(s) as your personal representative? This person would have the authority to schedule, confirm or change appointments only. If yes, please list first and last names.

Center for Advanced Eye Care / Advanced Eye Surgery Center has offered me with a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

Patient's Signature Date