735 N. 6th Ave
Wauchula, Fl 33873
(863) 773-3322

363 US 27 South
Sebring, Fl 33870
(863) 385-7070

2442 NE Hwy 70
Arcadia, Fl 34266
(863) 491-5854

27 U.S. 27 North
Lake Placid, Fl 33852
(863) 465-4904

New Patient Demographics/Demografía de nuevos pacientes

Name/Nombre: _____ Date of Birth/Fecha de Nacimiento: _____

Social Security #/Seguro Social: _____ Email/Correo Electronico: _____

Address/Direccion: _____ City/Ciudad: _____

State/Estado: _____ Zipcode/Codigo Postal: _____

Employer/Empleador: _____ Phone #/Telefono: _____

Alternate Phone #/Telefono Alterno: _____ Referred by/Referido por: _____

Marital Status/Estatus Civil: M S D W Sex/Sexo: Male/Hombre Female/Mujer Referred/Referido: Yes/Si or No

Primary Care Physician/Medico Primario: _____

Release of Information/Liberación de información

Pertaining to the Health Insurance Portability and Accountability Act of 1996 (HIPPA), below is our attempt to protect our patients' right of privacy. Your signature indicates the degree to which your information is to be released.... Referente a la Ley de Portabilidad y Responsabilidad del Seguro Médico de 1996 (HIPPA), a continuación se presenta nuestro intento de proteger el derecho de nuestros pacientes a la privacidad. Su firma indica el grado en que su información debe ser liberada.

Patient Name/Nombre del Paciente: _____ Age/Edad _____

( ) Make appointments/Hacer/venir a las citas
( ) Diagnosis/Diagnostico
( ) Treatment/Tratamiento
( ) Financial: Patient balance only/Informacion Financiera del paciente
( ) All of the above/Todo lo de arriba

Name/Nombre _____ Relationship/Relacion: _____

Name/Nombre _____ Relationship/Relacion: _____

Signature/Firma: _____ Date/Fecha: _____

HIPAA email consent VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information stored on our computers is encrypted.
- Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email
- When we send you an email or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the inofrmation and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on an email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email and the same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 - ALLOW UNENCRYPTED EMAIL I understand the risks of unencrypted email and do hereby give permission to Sevigny and Associates Eye Care to send me personal health information via unencrypted email

Signature: _____ DOB: _____

Printed name: _____ Date: _____

Please print email address: _____
(Parent or guardian if patient is a minor)

OPTION 2 - DO NOT ALLOW UNENCRYPTED EMAIL I do not wish to receive personal health information via email

Signature: _____ Date: _____

Printed name: _____
(Parent or guardian if patient is a minor)

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Fax (863) 773-6458

363 US 27 South
Sebring, Fl 33870
Ph (863) 385-7070
Fax (863) 385-7080

2442 NE Hwy 70
Arcadia, Fl 34266
Ph (863) 491-5854
Fax (863) 773-6458

27 U.S. 27 North
Lake Placid, Fl 33852
Ph (863) 465-4904
Fax (844) 656-0704

Records Release/Autorización de Liberación de Grabación

To/Para: _____ Fax: _____

Patient's Name/Nombre del paciente: _____

Date of Birth/Fecha de Nacimiento: _____

Address/Dirección: _____

City/Ciudad: _____ State/Estado: _____

Information to be released/Información a publicar:

___ Medical history, exam reports/Historial médico, informes de exámenes
___ Surgical reports/Informes quirúrgicos
___ Treatment or Test/Tratamiento o prueba
___ Hospital records including reports/Expedientes hospitalarios incluyendo informes
___ X-Ray reports/Informes de rayos X
___ Development Disabilities/Discapacidades de desarrollo
___ Laboratory reports/Informes de laboratorio
___ Prescriptions/Prescripciones
___ Consultations/Consultas ___ Other/Otro (specify/especificar): _____

Doctor requesting records/Doctor solicitando registros:

___ Mark D. Sevigny, OD
___ Ronald O. Sevigny, OD
___ Nick Timmerman, OD
___ Robyn Russell, OD
___ Daniel Black, OD
___ Angela Anderson, OD
___ Bradley Peltzer, OD
___ Glenn Thayer, OD

Purpose for need of Disclosure/Propósito de la necesidad de divulgación:

___ At the request of the individual/A petición del individuo

I understand that the health information disclosed as a result of the authorization may or no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization...
Entiendo que la información de salud revelada como resultado de la autorización puede o no estar protegida por las normas federales de privacidad y mi información de salud podría volver a ser revelada sin obtener mi autorización.

_____ _____
Signature of Patient,Parent,Guardian/Firma del Paciente,Padre,Custodio Date/Fecha

_____ _____
Signature of Witness/Firma del Testigo Date/Fecha