Avera Medical Group Ophthalmology Sioux Falls
Plaza 2
1301 South Cliff Avenue, Suite 220
Sioux Falls SD 57105
(605) 322-3790 • Fax (605) 322-3791

Patient Information

Patient Name: _____
(Last, First, Middle Initial)

Date of Birth:_____ Age:_____ Sex:_____ Marital status: _____

Phone: (H)_____ (C)_____ (W) _____

May we leave a general message on your phone? ❑ Yes ❑ No

HIPAA Acknowledgment

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Office at Avera McKennan Hospital & University Health Center.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices dated July 1, 2013.

Release of Information

I hereby authorize Avera Medical Group Ophthalmology Sioux Falls to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to the third party payers and/or their reviewing contractors to comply with preauthorization review for continued medical care. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

Assignment of Benefits

Authorization is hereby granted for the direct payment to Avera Medical Group Ophthalmology for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

Communication with Family and Friends

Avera Medical Group Ophthalmology may share medical and/or billing information with the following individuals who are involved with the patient's care. This could be a child/or parent who helps you with your medical care.

Release to:_____ Relationship: _____

Release to:_____ Relationship: _____

Consent for Photograph

I understand that photos of my eye may be taken as part of testing that I may need for continued eye care with Avera Medical Group Ophthalmology, to include: photographs, digital images, and ocular scans. I understand that the images indicted above may be recorded and I consent to this. The images will be maintained as a permanent part of the patient record.

Authorization For Treatment

Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic and medical treatment by Avera Medical Group Ophthalmology, and students in educational programs affiliated with Avera Medical Group Ophthalmology. I consent to testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

_____ _____AM / PM _____
Date Time Patient, Parent or Legal Representative Signature/Relationship to Patient