ZULEIKA M. GHODSI, MD, PC
DELAMRAVA LASER EYE CENTER

NEW PATIENT INFORMATION

Today's Date:_____ Email Address:_____

PERSONAL INFORMATION: *(Please Print)*

Patient Name:_____

Date of Birth:_____SS#_____
(ss #'s are secure and confidential at all times)

Circle: Male / Female Marital Status: Married / Single / Divorced / Widowed

Address:_____City_____

State_____Zip_____

Home Phone: (____)_____Cell: (____)_____

Employer:_____Work Phone_____

Primary Care / Family Doctor:_____

Address:_____Phone_____

Emergency Contact_____ Phone_____
In case of Emergency only

INSURANCE INFORMATION: (Please bring all insurance cards at time of visit)

Primary Insurance:_____Policy#_____

Group#_____Policyholder_____

Policyholder Date of Birth_____SS#_____

Secondary Insurance:_____Policy#_____

Group#_____Policyholder_____

Policyholder Date of Birth_____SS#_____

I agree that all my information is accurate and that my patient health information will be protected at all times.

I agree that I understand and have been provided with a copy of Delmarva Laser Eye Center's Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and recently updated and additions in the "Final Rule" effective September 23, 2013.

Patient Signature:_____Date_____
(Parent or Legal Guardian)

Permission to Discuss Medical Information

I give permission to Zuleika M. Ghodsi, MD, PC and Delmarva Laser Eye Center to discuss my medical information with the individual/s named below. I understand that NO ONE other than the person/s listed below will be permitted to receive or discuss medical information about me at any time without written permission from me.

Name _____

Contact Info:_____

Relationship_____

Name_____

Contact Info:_____

Relationship_____

I agree to allow the person/s named above to receive information regarding my medical records and health information from Zuleika M. Ghodsi, MD, PC and Delmarva Laser Eye Center. This agreement will remain effective until otherwise indicated by me in writing.

Patient Name:_____
(Please Print)

Signature:_____**Date:**_____
(If Minor Parent or Legal Guardian)

Delmarva Laser Eye Center
Zuleika M. Ghodsi, MD, PC

- I understand that I must present **ALL insurance *coverage*** ***(secondary carriers, eye or vision insurance, etc.)*** before being treated and that I understand that the practice is not able to bill insurance coverage not given at time of visit.

- I authorize the **release of all medical records** to consulting physicians and to my insurance company **unless otherwise indicated by written notice**.

- I understand that **payment of charges** incurred is due **at time of service.**

- I understand that I am responsible for **payment for services not covered by my insurance** company or Medicare, including routine health maintenance visits.

- I agree to pay all reasonable **attorney fees and collection cost** in the event of a default of payment of my charges.

- I agree to **receive calls and have messages left** at the numbers provided regarding appointment dates, times, etc. I would like all correspondence from Delmarva Laser Eye Center sent to my home unless otherwise indicated by written notice.

- I understand that when **contact lenses** are ordered my **account will be charged** unless previously arranged. I understand I have **30 days in which to pick up** contact lenses after being notified they are ready for pickup.

I have read and fully understand the above consent for financial responsibility, release of medical information, insurance authorization and contact policy.

Patient Signature:_____**Date:**_____

If Patient is a minor, parent's signature is required:

Parent Signature:_____**Date:**_____