



Welcome to Our Office

Last Name: _____ First Name: _____ Middle Initial _____

Name by which you like to be called/nickname: _____

MR MRS MS DR Marital Status: S M D W DP

Date of Birth: _____ SS#(if using vision insurance) _____ - _____ - _____

Name of Vision Insurance: _____

Employer/ School: _____ Occupation/Grade: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Daytime Phone: _____

Cell Phone: _____ Email Address: _____

Family Physician (PCP): _____ Former Eye Doctor: _____

Do you wear: [] glasses
[] contact lenses Name of Contact Lens _____
Right Eye: Power _____ Base Curve _____
Left Eye: Power _____ Base Curve _____
[] no correction
[] history of refractive surgery (LASIK, PRK, RK, etc.)

Has any member of your family been our patient? _____

How did you hear about us?
[] I was referred by _____ (who may we thank for referring you?)
[] I saw an add in the yellow pages
[] I saw a listing of participating eye care providers from my insurance company
[] Other : _____

MOST VISION INSURANCE PLANS DO NOT PAY FOR BOTH AN EXAMINATION FOR GLASSES, AND AN EVALUATION OF YOUR CURRENT CONTACT LENSES. THERE WILL BE AN ADDITIONAL CHARGE IF YOU CHOOSE TO HAVE BOTH SERVICES.

I hereby authorize payment directly to Dr. Anne E. Savko for any insurance benefits, otherwise payable to me, for her services as described on the attached claim form. I understand that I am financially responsible for any charges not reimbursed by my insurance company.

Long time authorization/ financial responsibility / "signature on file".

Signature: _____ Date: _____



Receipt of Notice of Privacy Policies & Consent Form

ANNE E. SAVKO, OD
1338 N. MOORPARK ROAD
THOUSAND OAKS, CA 91360
(805) 495-5510
(805) 373-8570 (FAX)

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Dr. Savko.

Signature _____ Date _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient _____ Print Name _____