Sunset Eye Clinic, LLC Patient Information

Jacob Janecek, O.D. & Kenny Lee, O.D.
1865 NW 169th Place, Suite 105
Beaverton, OR 97006
Phone 503 533 8441
Fax 503 533 8403

Welcome to our office!

Patient Name_____ Date____/____/____

Date of Birth____/____/____ Insurance ID # _____

Address_____ Home Phone _____

City/State/Zip _____ Work Phone_____

E-mail Address _____

Person responsible for payment (other than insurance) _____

Please check here if billing address is different from the address listed above. ☐

Whom may we thank for referring you to our office?

Other healthcare professional _____

Family member _____

Friend _____

☐ Internet
☐ Yellow Pages
☐ Insurance list
☐ Other (Specify)

Insurance Information

Vision Care Insurance
Name of the Company _____ Phone #_____

Name of Insured _____

Group # or Employer Name _____Insurance ID#_____

Major Medical Insurance
Name of the Company _____ Phone #_____

Name of Insured _____

Group # or Employer Name _____Insurance ID#_____

Primary Care Provider _____

Payment Policy

Payment is due at the time of service. We accept cash, checks, Visa, and MasterCard. If you have insurance, we will be happy to bill the estimated portion your insurance plan covers; the remaining balance is due at the time of service. Your carrier is your best source of information regarding benefits and eligibility.

Signature _____ Date____/____/____

SUNSET EYE CLINIC, LLC

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Patient name _____

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 your health information for treatment purposes. This not only includes care and services provided here, but also may be necessary for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information may be needed for processing claims, determining benefits, and/or obtaining payment from a third party.

When you sign this consent document, you agree that Sunset Eye Clinic may use and disclose your health information to treat you, to obtain payment for our services, and to perform health care referrals. By signing, you also agree that a copy of the **Notice of Privacy Practice** was available for you to read. If you have any questions regarding the Notice of Privacy Practice please ask the receptionist.

If you sign this authorization, you may revoke this consent in writing at any time unless we have already performed actions in reliance with this consent.

I _____, HAVE READ AND UNDERSTAND THIS CONSENT DOCUMENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I HAVE READ AND UNDERSTAND SUNSET EYE CLINIC'S NOTICE OF PRIVACY PRACTICE.

_____ _____

Date Signature Patient/Guardian