Welcome to Gerstein Eye Institute

PLEASE PRESENT YOUR INSURANCE CARD(S) & ID AT THE FRONTDESK

Name_____
Last Name First Middle Initial Parent/ Guardian/ Other

Address _____
Street City State Zip

Home Phone (_____)_____ Date of Birth ____/____/____ Age _____ SS# _____-_____- _____

Cell Phone (_____)_____ ☐ Male ☐ Female E-Mail Address _____

How did you learn about our practice? ☐ Billboard ☐ Internet ☐ Patient ☐Family/Friend ☐Walk In

☐Yellow Pages ☐Insurance ☐Doctor(name)_____ ☐Other(please specify)_____

Employer _____ Business Phone (_____) _____

Name of Insured (may be spouse) _ _____

Insured Employer _____ Insured Business Phone(_____)_____

Let us send a thank you note to your doctor for your referral!

Referring Doctor/ Primary Care Doctor_____

Address_____ Phone (____)_____

Pharmacy Name _____Address_____Phone(_____)_____

Gerstein Eye Institute
Summary Notice of Privacy Practices

The following information is a summary of the **Notice of Privacy Practices**, which is attached in full text. **This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.**

We are required by law to maintain the privacy of your medical information. We must provide you with a copy of this notice. We must follow the terms of this notice. If the notice is changed in any material way, a revised notice will be available upon request.

We will use your medical information for Treatment. For example, we may consult with your primary care physician. We must use your medical information for payment, for example, we may need to give your insurance plan information about your diagnosis, treatment and the supplies used. We will use your medical information for Health Care Operations. For example, we may use your medical information to evaluate our services. We may contact you at any phone number or address you have provided to us to remind you of an appointment or other health care matters or to obtain payment for our services.

We may use and disclose your medical information to inform you of treatment alternatives or other Health related benefits and services. We may disclose your medical information to family members or others who are involved in your care or payment for that care. You must notify our Privacy Officer in writing if you do not want us to communicate with you in any of these ways.

We may use your medical information for any uses that are required or permitted by law. Other uses and disclosures will be made only with your written authorization. You may cancel an authorization at any time by notifying our Privacy Officer in writing.

You have the following rights: Right to privacy notice; Right to request restrictions on uses and disclosures of your medical information; Right to receive confidential communication; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and a Right to an accounting of disclosures of your medical information.

Contact Information. If you feel your privacy rights have been violated, please contact our Privacy Manager Juleidy Cruz at (773) 973-3223 or the U.S Secretary of Health and Human Services. As indicated by my Signature below I hereby acknowledge receipt and understanding of the Notice of Privacy Practices.

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative Description of Personal Representative's Authority to Act on Patient'sBehalf