Hall Eye Care Center, L.L.C.

Established Patient Update Form

In order for our office to have the most accurate information, please update the following information.

Name: _____ Birthdate: _____

Address: _____

Home phone: _____ Cell phone: _____

E-mail address _____

What medications are you currently taking? (Please list *all* medications)

_____

_____

_____

Are you allergic to any medications? If yes, please list _____

_____

Please list any personal health changes since your last visit (e.g. diagnosis of disease or disorder, injuries, surgeries, etc.) _____

_____

_____

Please list any health changes ***in your immediate family*** since your last visit _____

_____

_____

_____

(For Office Use Only)

HALL EYE CARE CENTER, L.L.C.
ALLISON N. HALL, O.D.
#1 COLONIAL SQUARE
CLARKSVILLE, ARKANSAS 72830
(479) 705-2022

HIPAA – Patient Acknowledgement Form

I, _____, hereby acknowledge receipt of Hall Eye Care Center's Notice of
(Patient's Name)

Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I authorize release of any medical information necessary to process insurance claims and payment of medical benefits directly to Dr. Hall/Hall Eye Care Center.

I understand that Dr. Hall/Hall Eye Care Center will not discuss my medical information, dispense prescriptions, glasses, or contacts to anyone without my consent.

I authorize Dr. Hall to release my protected health information and to dispense contacts or glasses to:

Only Myself _____

Doctor: _____Phone:_____ Doctor: _____Phone:_____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____Phone:_____

Note: Anyone who is not listed above will not be able to pick up prescriptions, glasses, or contacts. This includes a spouse or a family member who is not listed above.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

_____
(For Office Use Only)