BARENBURG EYE ASSOCIATES

Patient Registration

❍ **Park** ❍ **Dundalk** ❍ **Ellicott City** ❍ **Pikesville** ❍ **Garwyn**

Dr. Mark Gordon
Dr. Shoshana Cohen
Dr. Joshua Gordon
Dr. Rita Vekker
Dr. Ross Fischer
Dr. Jonathan Ekedahl
Dr. Robert Loeb
Dr. Karl Malicdem
Dr. Selvin Gnanakkan

Patient Name (Last, First, Middle) (Mr./Mrs./Miss/Dr.)

Home Address			City, State, Zip
Home Phone	Work Phone	Cell Phone	Email Address
Patient's Occupation ☐ Student			Social Security Number
Date of Birth	Age	Sex	Marital Status S M D W
Patient's Employer			Referred By

Insurance Information

Name of Primary Insurance		Secondary Insurance	
Address		Address	
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Employer		Policy Holder's Employer	
Policy Holder's Date of Birth	Sex	Policy Holder's Date of Birth	Sex
Insurance Number		Insurance Number	
Policy Holder's SS #		Policy Holder's SS#	

Patient's Authorization

I hereby authorize BARENBURG EYE ASSOCIATES to apply for benefits on my behalf for covered services rendered and request that payment be made directly to BARENBURG EYE ASSOCIATES. I certify that all the information in regards to my insurance is correct and further authorize the release of any necessary information for this or any related claim. I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time in writing. I certify that all the information provided on this form is valid and will accept any and all responsibility caused by incorrect information. I understand that I am financially resposible for the charges not covered by insurance.

Patient or Guardian Signature	Date

BARENBURG
EYE ASSOCIATES

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PLEASE PRINT CLEARLY

Patient Name:	Patient Home Phone Number:
Patient Address:	Patient Cell Phone Number:
	Patient Email Address:
Location of Clinical Records: (Please check one) ❍ Park ❍ Dundalk ❍ Pikesville ❍ Ellicott City ❍ Garwyn	

I authorize Barenburg Eye Associates, Inc. to release health information identifying me under all circumstances pertaining to my eye care.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to:

Ellen Gordon
100 Park Avenue
Baltimore, Maryland 21201

As applicable, we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization. Information will only be provided sufficient to allow authorization and payment of services by a third party.

As applicable, we may call you or send you a postal card, email or text message reminding you to schedule an appointment, or to notify you that your eyewear is ready.

In all instances, Barenburg Eye Associates will show prudence and release only the minimum protected information necessary to a particular disclosure.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

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

Relationship to Patient _____ Print Name _____

Source of Authority _____

---------- Please Sign Below ----------

ACKNOWLEDGMENT OF RECEIPT

I ACKNOWLEDGE THAT I READ A COPY OF BARENBURG EYE ASSOCIATES' NOTICE OF PRIVACY PRACTICES.

PATIENT NAME _____

SIGNATURE _____ DATE _____

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O*P!Q-R!0J?@;!KCKLKKM@! ! ! !!!! ! O*P!Q-R!!0J?@;!DNCL?@JC! ! ! ! !

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