**Please provide an email address for any updates, newsletters, billing, and confidential communications.**

**EMAIL**: _____

**Please circle your preferred type of communication:**

Home Phone  Cell Phone  Text Message  Email

## HIPAA (Privacy Policy) Acknowledgment

I have received a copy of the HIPAA Privacy Policy of this office and have read, understood, and agreed to all the information.

Print:_____

Sign:_____Date:_____

## Electronic Health Records

**The government now requires every medical office to ask the following questions, it is optional to answer.**

**RACE**:

American Indian  Black  Native Hawaiian  Asian  Caucasian  Other

**ETHNICITY**:

Hispanic or Latino  Not Hispanic or Latino  No Answer

**PREFERRED LANGUAGE:**

American Sign Language  Arabic  English  French  German  Italian

Korean  Polish  Spanish

**HEIGHT**: ____ft____in  **WEIGHT**:_____lbs


Holt Eye Care

2040 North Aurelius Suite 20

Holt, Michigan 48842

## Confidential Communications

I authorize the practice of leaving a message on my answering machine/voicemail: □ YES □ NO

**FOR APPOINTMENT REMINDERS ONLY:**

1) Use Cell Phone: □YES _____□NO

2) Use Email: □YES _____□NO

I authorize the release of my protected health information over the telephone or in person to the following individuals (Please put N/A over this section if not applicable):

1. Name of person:_____
   Relationship:_____

   Primary contact number: _____

2. Name of person:_____
   Relationship:_____

   Primary contact number: _____

3. Name of person:_____
   Relationship:_____

   Primary contact number: _____

*(If communication with primary doctor or referring doctor is needed, no additional authorization is required)*

***By signing, you agree for us to bill your insurance and understand that you are responsible for any charges your insurance doesn't cover. Additionally, a restocking fee may apply to any returned glasses and/or contacts.**

Patient Signature: _____ Date: ____/____/_____