# Kittery Optometric Associates

**99 US Route 1 Bypass**
**Kittery, Maine 03904**

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Patient Last Name: | First: | MI: | Sex: |
| | | | ❑ M ❑ F |
| Birth Date: (MM/DD/YYYY) | SS# | Email Address | |
| / / | - - | | |
| Home phone no.: | Cell phone no.: | Work phone no.: | |
| ( ) | ( ) | ( ) | |
| Mailing address: | City: | State: | ZIP: |
| | | | |
| Race | Ethnicity | Preferred Language | |
| ☐ White ☐ Asian<br>☐ African American ☐ Other __________ | ❑ Hispanic<br>❑ Non-Hispanic | ❑ English<br>❑ Other ____________ | |
| Contact Preference: check all that apply | | | |
| ❑ Email/Portal ❑ Mail ❑ Home Phone ❑ Cell Phone ❑ Work Phone | | | |

| INSURANCE INFORMATION | |
|---|---|
| (If you are the subscriber on your insurance(s), you may leave this portion blank) | |
| Subscriber's name: | Relation to patient: |
| | |
| Address (if different): | |
| | |
| Birth Date (MM/DD/YYYY): | |
| / / | |

**Please continue to 2nd page**

# Kittery Optometric Associates

**99 US Route 1 Bypass**
**Kittery, Maine 03904**

## INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payments of the benefits to Kittery Optometric Associates [KOA] for any service and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I understand that submission of a claim to my insurance company does not guarantee coverage or payment and I may be personally responsible for services and/or materials fees charged by KOA.

Signature:________________________________________ Date: ______________________________

(We must have a signature on file in order to bill an insurance company on your behalf.)

## RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Kittery Optometric Associates, which sets forth the ways in which my personal health information may be used or disclosed by Kittery Optometric Associates, and outlines my rights with respect to such information.

Signature:________________________________________ Date: ______________________________

## Authorization to disclose information:

I give Kittery Optometric Associates permission to speak to __________________________________ regarding my medical and financial information.

Relationship:______________________________________ Contact Number:___________________

Signature:________________________________________ Date: ______________________________

## **RECEIPT OF NOTICE OF PATIENT PORTAL AGREEMENT

I acknowledge that I have read and fully understand the Patient Portal Use Agreement. I understand the risks associated with online communications between Kittery Optometric Associates and patient, and consent to the conditions outlined herein. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that Kittery Optometric Associates may impose for using the Portal. By signing below, I hereby give my informed consent to participate in Kittery Optometric Associates Portal, and I hereby agree to and accept all of the provisions contained above.

Signature:________________________________________ Date: ______________________________