ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Mesquite Eye Associates "Notice of Privacy Practices." This Notice describes how Mesquite Eye Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected information. This office uses an automated system to text and email patient reminders and recalls.

_____
(Signature of Patient, or Guarantor)

MEDICAL RELEASE

I, _____ give my permission for Mesquite Eye Associates to receive medical records from my physicians or give my medical records to any physician that Dr. Karl Kutch or any of his associates refer me to.

_____ Date_____
(**Signature of Patient, or Guarantor)**

_____
(Relationship to Patient)

DEPENDENT/SPOUSE AUTHORIZATION

I give my permission for Mesquite Eye Associates to discuss my medical records and billing information with the following_____

_____

Inititals_____

MEDICAL TREATMENT

I authorize all staff and physicians at Mesquite Eye Associates to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my physician during any and all visits to Mesquite Eye Associates.

Signature_____ Date_____

FINANCIAL RESPONSIBILITIES

This office may be billing insurance claims on behalf of the patient. If, for any reason your insurance does not pay for any services you have received, you (the patient or guarantor) will be responsible for any and all charges. If, you do not pay your balance in full there could be additional fees, service charges or interest assessed to your bill.

**Vision plans cannot be billed for any patient being seen with a medical eye conditions.

MEDICAL HISTORY

Have you ever had any of the following;
(Please check all that apply)

Eye Injuries_____
Amblyopia (lazy eye)_____
Flashes_____ Date_____
Floaters_____ Date_____
Eye Turn_____
Eye Infections_____
Dry Eye_____
Thyroid Disease_____
High Blood Pressure_____
High Cholesterol_____
Heart Disease_____
Stoke_____
Cancer_____
Rheumatoid Arthritis_____
Multiple Sclerosis_____
Cataract_____
Glaucoma_____ Family History of Glaucoma_____
Macular Degeneration_____ Family History of Macular Degeneration_____
Diabetes_____ Family History of Diabetes_____

MEDICATIONS

List all medications: (dosage and mg)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Contact Phone_____
Email _____