Exhibit 9

Southpoint Eye Care, P.C.
Patient Information

PLEASE PRINT

PATIENT

LAST NAME	FIRST NAME	MIDDLE	NAME CALLED	
STREET ADDRESS	APPT #	CITY	STATE ZIP	MARITAL STATUS
AREA CODE HOME PHONE	AREA CODE CELL PHONE	SOCIAL SECURITY #	SEX	DATE OF BIRTH / AGE
EMPLOYED BY		SPOUSE'S NAME	EMPLOYED BY	
EMPLOYERS ADDRESS		EMPLOYERS ADDRESS		
OCCUPATION	BUS. PHONE & EX	OCCUPATION	BUS. PHONE & EX	
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU		RELATIONSHIP TO PATIENT	PHONE	

POLICY HOLDER/INSURANCE INFORMATION

COPIES OF INSURANCE CARD REQUIRED

PRIMARY

LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP TO PATIENT
STREET ADDRESS	APPT #	CITY	STATE ZIP
DATE OF BIRTH	SOCIAL SECURITY #		HOME PHONE
EMPLOYED BY		BUS. PHONE	

Insurance Co. Name _____

Mailing Address _____ City, State, Zip _____

(A/C) Phone # ( ) _____-_____ ( ) _____-_____

Policy/Contract # _____ _____

SECONDARY

LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP TO INSURED (ALIAS)
STREET ADDRESS	APPT #	CITY	STATE ZIP
DATE OF BIRTH	SOCIAL SECURITY #		HOME PHONE
EMPLOYED BY		BUS. PHONE	

Insurance Co. Name _____

Mailing Address _____ City, State, Zip _____

(A/C) Phone # ( ) _____-_____ ( ) _____-_____

Policy/Contract # _____ _____

REFERRING INFORMATION

REFERRAL SOURCE _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES **(Turn Over)**

This is to acknowledge that I have received a copy of (Practice Name) Notice of Privacy Practices.

Date:_____ **Signature:**_____ **Relationship to Patient:**_____

Exhibit 9

Southpoint Eye Care, P.C.
Patient Information

I REQUEST THAT PAYMENT OF AUTHORIZED benefits be made to Southpoint Eye Care, P.C.
I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

DATE _____ **Signature** _____

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.

I hereby assign and authorize payment to Southpoint Eye Care, P.C. of all medical and/or surgical benefits, including major medical policies, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees andcharges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those feesand charges not directly reimbursed to Southpoint Eye Care, P.C. by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION _____

RELATIONSHIP TO PATIENT IF NOT PATIENT _____

Date _____

ALTERNATIVE CONTACT AUTHORIZATION

I ☐ DO ☐ DO NOT authorize you to contact or leave messages at my place of work.

Date: _____ Signature: _____

I ☐ DO ☐ DO NOT authorize you to contact me at my e-mail address.
(e-mail address if authorized _____)

Date: _____ Signature: _____

I hereby authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are **available**. The laboratory **results** are NEVER left on the answering machine. You have to call the office to get them.

Date: _____ Signature: _____