THE EYE CENTER

Today's Date: _____

Patient's Name:

First *Middle* *Last*

Address

Street & Apt # *City* *State* *Zip*

SS#: Birthdate: Age: Sex:

Marital Status: Married to: ☐ Other:

Home Phone: Cell Phone: Work Phone:

Emergency Contact: Relationship to Patient: Phone:

☐ I agree to have my health information discussed with the above person

Preferred Pharmacy: Phone:

Street Name / City / State / Zip

Patient's Employer: Occupation:

Ethnicity: Language:

Race: Email:

How did you hear about us? ☐ Friend ☐ Insurance ☐ Internet ☐ Other Details:

Referring Doctor: Primary Care Doctor:

INSURANCE INFORMATION

Primary Insurance: **ID #:** **Group #:**

Insured: DOB: SS #:

Relationship to the insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

Secondary Insurance: **ID #:** **Group #:**

Insured: DOB: SS #:

Relationship to the insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

Vision Insurance: **ID #:** Group #:

Insured: DOB: SS #:

Relationship to the insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

PLEASE SEE REVERSE SIDE TO COMPLETE

WE ACCEPT ASSIGNMENT ON PART B MEDICARE PATIENTS. YOU WILL BE EXPECTED TO PAY YOUR DEDUCTIBLE AND 20% COINSURANCE. WE WILL ONLY FILE TO ONE SECONDARY POLICY.

MEDICARE AUTHORIZATION

I understand that my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of medical information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and the uncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Name: _____ *Date:* _____

Signature: _____ *Medicare Policy #:* _____

FINANCIAL CONTRACT / RELEASE OF INFORMATION / CONSENT TO TREAT AGREEMENT

The Eye Center, Inc. is committed to your successful treatment. Please understand that payment of your account is considered a part of your treatment. If you do not have your current insurance card at the time of service, you will be treated as a "self pay" patient.

- All co-pays are due prior to seeing the physician (we accept Cash, Checks, MasterCard, Visa, Discover and American Express).
- All "self pay" patients are asked to pay this visit fee in full at the time of service unless other prior arrangements are made.
- All patients covered under an HMO plan must have a valid referral at the time of their visit.
- The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of the account.
- **Refractions are not covered by Medicare or most insurances. The $50 fee is due at the time of the visit.**
- Once per calendar year we assess a contact lens evaluation fee (often covered by vision plans).

I authorize the use of this form on all insurance submissions and authorize release of information needed to process a claim to my insurance companies and permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in obtaining payment from my insurance companies, but understand the provider is not responsible for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand it is my responsibility to know my insurance benefits and that I will receive a monthly statement for any balance due by me. All returned checks will be assessed a $30 fee.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. We are not liable for any misquoted benefit information. **You are fully responsible for verifying the benefits of your policy.**

I consent to the medical and surgical care as deemed advisable by my physician.

I understand and agree to the Agreement as stated above:

Initials: _____ *Date:* _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES / WRITTEN ACKNOWLEDGMENT FORM

I have received a copy of The Eye Center Notice of Privacy Practices.

Patient Name (please print):_____

Signature: _____ *Date:* _____

The above authorizations are valid for one year from date signed unless retracted in writing by the patient