PRIMARY EYE CARE CENTER

Patient Information

WELCOME TO PRIMARY EYE CARE CENTER, P.C.

(PLEASE *PRINT* INFORMATION CLEARLY - RETURN COMPLETED FORM TO THE FRONT DESK)

MR./MRS/
MS./MISS____________________

LAST NAME   FIRST NAME   MIDDLE   MAIDEN NAME

______/______/____________________

SOCIAL SECURITY #   MARITAL STATUS   SEX   AGE   DATE OF BIRTH

____

STREET ADDRESS (NOT A POST OFFICE BOX)   APT. NO.

____

CITY   STATE   ZIP CODE   HOME PHONE #

____

EMPLOYER'S NAME   EMPLOYER'S ADDRESS   YOUR OCCUPATION   BUS. PHONE # (EXT.)

____

SPOUSE NAME   EMPLOYED BY   EMPLOYER'S ADDRESS   BUS. PHONE # (EXT.)

____

NAME OF NEAREST FRIEND/RELATIVE NOT LIVING IN SAME HOUSEHOLD   RELATIONSHIP TO PATIENT   PHONE #

HOW WERE YOU REFERRED TO OUR PRACTICE? (Please check all that apply)

☐ Your Physician ☐ Optometrist ☐ Patient ☐ Radio ☐ Neighbor ☐ Newspaper ☐ Yellow Pages ☐ Friend ☐ Other

Name of Above Referrer____________________ Address____________________

____

WHO IS YOUR PRIMARY CARE PHYSICIAN____________________ City/Town____________________

UNDER THE HIPAA REGULATIONS, WE ARE REQUIRED TO OBTAIN THE NAME(S) OF THE PERSON(S) AUTHORIZED BY YOU TO RECEIVE INFORMATION ABOUT YOUR HEALTHCARE

Please list the family member(s) or other person(s), if any, whom we may inform about your general medical condition(s) and your diagnosis. <u>If an individual requests information about your medical condition and is not listed below, we will not be able to discuss your medical condition with said individual.</u> The HIPAA Privacy Rule requires this information so that your health information remains confidential.

____

INSURANCE INFORMATION - Please have health insurance card(s) available for photocopying

____________________   ____________________

Primary Insurance Company Name & ID number   Secondary Insurance Company Name & ID number

WILL THESE SERVICES BE COVERED UNDER WORKERS' COMPENSATION? Yes______ No_____

____

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT OF SERVICES <u>AND</u> FOR <u>CHILDREN UNDER AGE 18</u>

MR./MRS/
MS./MISS____________________

NAME   ADDRESS   CITY   STATE   ZIP CODE

____

HOME PHONE #   RELATIONSHIP TO PATIENT   OCCUPATION

____

EMPLOYER   EMPLOYER'S ADDRESS   CITY   STATE   ZIP CODE   BUS. PHONE #

Please turn page over and sign at the "X"

Signature on File, Assignment of Benefits, Financial Agreement

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Primary Eye Care Center, PC for services furnished me by Primary Eye Care Center, PC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that 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, my signature authorizes releasing the information to the insurer or agency shown. Primary Eye Care Center, PC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Primary Eye Care Center, PC, if possible or otherwise to me.

3. RELEASE OF INFORMATION: Primary Eye Care Center, PC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Primary Eye Care Center, PC for reimbursement for services rendered, & (2) any health care provider for continued patient care. Primary Eye Care Center, PC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. MANAGED CARE INSURANCE: I understand that Primary Eye Care Center, PC maintains a list of healthcare maintenance organization (HMO) plans with which it contracts. A list of such plans is available from the business office. Primary Eye Care Center, PC has no contract, expressed or implied, with any HMO plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Primary Eye Care Center, PC if I belong to an HMO plan that does not appear on the above-mentioned list.

5. NON-COVERED SERVICES: I understand that Primary Eye Care Center, PC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Primary Eye Care Center, PC to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Primary Eye Care Center, PC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Primary Eye Care Center, PC for payment. I understand that I am individually obligated to pay the full charges of all services rendered to me by Primary Eye Care Center, PC even if I am not covered by any health insurance plan. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Primary Eye Care Center, PC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Primary Eye Care Center, PC. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

7. CONSENT: By signing this form, you are granting consent to Primary Eye Care Center, PC to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our *Notice of Privacy Practices* provides more detailed information about how we may use and disclose this protected health information. You may have a legal right to review our *Notice of Privacy Practices* before you sign this consent, and we encourage you to read it in full. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent, in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

X ______________________________   ____________________

Patient Signature   Date

FOR OFFICE USE ONLY

Information & ID verified	Information & ID verified	Information & ID verified	Information & ID verified	Information & ID verified