PATIENT INFORMATION

PLEASE PRINT Today's Date ____________

Patient Name ____
First Middle Last

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Age ______ Birth Date ____________ SS # ____________ Home Phone # ____________

Physical Address ______________________________________ Cell Phone # ____________
Street

____
City State Zip

Mailing Address (if different) ____
Street City State Zip

Place of Employment ______________________________ Employer Phone # ____________

Do you have insurance? ☐ Yes ☐ No **Name of Insurance Company(s)** ____________

Emergency Contact (Name of person **other than spouse** we should notify.)

Name ______________________ Relationship ____________ Phone # ____________

RESPONSIBLE PARTY INFORMATION (Please fill out if the patient is under the age of 18 **OR** if the insurance policy holder information **is not the same** as the patient.)

Responsible party ______________________ Relationship ____________ D.O.B. ____________

Address ____

Phone # ____________ Cell Phone # ____________ SS # ____________

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN BELOW.

I request that payment of authorized Medicare benefits be made on my behalf to Eye Care Surgery Center for any services furnished by that provider. I authorize the holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

****PLEASE NOTE****

Medicare, Medicaid, and most other insurance carriers **WILL NOT** pay for **Refractions** (testing for glasses) or **Routine Eye Exams** (exams for blurred vision, headaches, or yearly exams not related to medical diseases).

The fee for **Refractions** (testing done to give prescription for glasses) is **$25**. This fee **PLUS** any co-payment or deductible is **DUE AT THE TIME OF SERVICE.**

I have read and understand the above information regarding fees for service.

______________________________ ____________________
Signature of Patient (or Representative) **Date Signed**

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PATIENT CONSENT FOR TREATMENT

I hereby authorize Eye Care Surgery Center Physicians, together with associates and assistants of his/her choice, to administer or perform a medical exam, any diagnostic testing and medical treatment, procedures, therapy, surgery and any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

X ____ ____________________ ________ **am/pm**
Patient (or person authorized to consent for patient) **Date** **Time**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ASSIGNMENT OF HEALTH INSURANCE BENEFITS:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health insurance about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our Office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that statement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment or health care operations.
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
* The Practice reserves the right to change the Notice of Privacy Policies.
* The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* The Practice may condition treatment upon the execution of this Consent.

I further acknowledge that I will be responsible for the payment of all charges for professional services and/or goods received regardless of whether or not I have insurance coverage.

Patient Signature: ____

This Consent was signed by: ____
Printed Name - Patient or Representative

Relationship to Patient (if other than patient): ______________________________________

Date: ________________________

In front of ______________________________
Printed name - Practice Representative