KIRK EYE CENTER

Patient Information

Last_____ First_____ MI_____ Date _____

Address _____ SSN Last 4 Digits_____

City _____ State _____ Zip _____ Birth Date _____

Home Phone _____ Cell _____ Work_____

Email _____

Preferred Phone: ❑ Home ❑ Cell ❑ Work

Race: ❑ Asian ❑ Black/African American ❑ White ❑ American Indian/Alaska Native
❑ Decline to Specify ❑ Other _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Decline to Specify

Language: ❑ English ❑ Spanish ❑ Other _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Insurance (subscriber)

Subscriber Name _____ Relationship _____

Subscriber Address_____ Birth Date _____

Secondary Insurance (subscriber)

Subscriber Name _____ Relationship _____

Subscriber Address_____ Birth Date _____

Employer _____

Address _____City _____ State _____ Zip _____

Primary Care Doctor _____ Phone _____

Address _____City _____ State _____ Zip _____

I have received a copy of the Notice of Privacy Practices_____(initial here)

PLEASE LET US KNOW HOW YOU HEARD ABOUT OUR OFFICE

❑ Newspaper ❑ Sign on Building/Drove By ❑ Radio/Television/Internet
❑ Friend/Family Member _____
❑ Doctor/Optometrist: _____

Please turn over and sign page 2

AGREEMENT OF RESPONSIBILITY

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductible, co-insurances and any non-covered services will be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

As a courtesy to you, our billing department will bill your insurance company for your visits in our office. Please remember it is still **your** responsibility to know your insurance plan and benefits.

Recently, insurance companies have made many changes. Most companies are now requiring that claims be submitted within 30 days. If the claim is delayed because of lack of information received by you, the claim will become your responsibility. If you are on an HMO plan, they require referrals for most services. It is your responsibility to obtain all referrals before services are rendered. If you fail to obtain a referral and request that services be rendered, you will be asked to pay for the services at the time they are rendered. Once you receive a referral, your insurance will be billed. If your insurance company pays for the services rendered, you will be refunded.

Please be aware that most insurance companies do not cover routine eye exams. If you only have medical coverage and have no medical complaint or medical diagnosis, then you will be responsible for your bill. We allow forty-five (45) days from the date of billing for insurance to pay their portion of your account. Your help in seeing that your claim is paid within this time frame is greatly appreciated. Insurance claims that are or not paid in full within forty-five (45) days will be your personal obligation. This includes, but is not limited to, office visits, office procedures, optical, and surgical fees.

At the initial time of service, you will be asked to complete a patient registration form. After the initial visit, you will be asked to verify your insurance on file so that any changes can be made to your file. If your insurance, address, or phone number changes at any time throughout the course of your care with us, please notify us right away.

REFRACTION SERVICE FEE

A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. We highly recommend a refraction as an essential component of a comprehensive exam. A refraction is NOT a covered service by Medicare or most insurance plans. These plans consider a refraction a "vision" service and not a "medical" service. Our office charges a refraction fee that is collected at the time of service in addition to any co-payment your insurance plan may require. Should your plan pay us for the refraction, we will reimburse you.

CONSENT TO TREAT

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE)

I authorize use of this form on all my insurance submissions (including Medicare) and authorize release of information needed to process a claim to all my insurance companies (including Medicare). I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies (including Medicare). I understand the provider does not accept a settlement on disputed claims. I assign all right and claim for reimbursement of expenses allowable under my insurance plan (including Medicare) and authorize payment directly to the provider for services rendered. I understand that I will receive a monthly statement for any balance due by me. This assignment shall remain in effect until revoked by me in writing.

MEDIGAP FOR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits or Secondary Insurance be made either to me or on my behalf to the Kirk Eye Center, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap or other Secondary Insurer, any information needed to determine the benefits payable for related services. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

My signature below states I have read and understand the above stated policies.

Signature_____ Date_____