Acct# **Patient Information**

Patient Name:	Home Telephone:
Social Security Number:	Work Telephone #:
Sex Race Language Ethnicity	Cell Telephone #:
Date of Birth: Age	eMail:
Address:	Emergency Contact Name & Phone:
City, State & Zip Code:	Relationship to Patient:
Family Physician Name/Address/Phone:	Referring Physician Name/Address/Phone:
Employer Name/Address: ____ ______ Full Time ___ Part Time ___ Unemployed ___ Retired ___	Student Status: Full Time Part Time Marital Status: Married Single
Pharmacy Name/Address/Phone/Fax:	Medicare Patients: Do you currently reside in a Skilled Nursing Facility? YES NO Facility Name:

Insurance Information

	Insurance Company	Subscriber	Subscriber DOB	Relationship
Primary				
Secondary				
Tertiary				
Vision Plan				

Financially Responsible Person (*For all patients under 18 years of age. Parent bringing MINOR child to office.*)

Full Name:	Social Security Number:
Address:	Home Telephone #:
City, State & Zip Code:	Work Telephone #:
Date of Birth (mm/dd/yyyy):	Cell Telephone #:
Relationship to Patient: Parent Guardian Other	

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Ocean Eye Institute for services provided. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Medicare Patients

If you are covered by Medicare, please read and sign the following:
In Medicare cases, Ocean Eye Institute agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Covered Benefits: As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for services and verify referral/authorization requirements.

Co-Payments: Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa, Master Card, American Express or Discover).

Medicare Program: Our practice participates in the Medicare program. We will collect the **20% not covered** by Medicare at the time of your visit. Since you are also responsible to meet your Medicare deductible, we will need to collect that amount as well.

Refraction Fee: A "Refraction" is a standard part of your eye exam. This test is necessary to determine your eyeglass prescription; however, it is *NOT COVERED* by *MEDICARE* and *MOST COMMERICAL* insurance Plans. A refraction fee of $49 will be collected at the time of your visit.

I have read the above statements. It is my understanding that I am financially responsible to Ocean Eye Institute for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to Ocean Eye Institute. I agree to pay the full amount of all charges incurred by the above named patient that are not covered by my insurance carrier.

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Patient Signature ***or*** If the Patient is a minor Parent/Guardian Signature Date

Patient Name: ______________________________ **Acct#:** ____________ **Date:** _____________

HEALTH QUESTIONNAIRE

What brings you to our office? Briefly explain any current eye problems. _____________________________

____

____ Routine Eye Exam

____ Referred by my physician or optometrist

____ Considering contact lenses

Do you smoke? _____ How long? _____

Are you taking any medication? ____

____

Are you allergic to any medication? ____

Family History. Please check any of the following. _____Glaucoma _____ Cataracts _____ Diabetes

_____ Retinal Problems _____ Blindness _____ Other

____

NOTICE OF PRIVACY PRACTICES

I authorize Ocean Eye to share medical and financial information to the following person. This will remain in effect until I makes changes.

Name ____________________________________ Relationship ____________________________

Name ____________________________________ Relationship ____________________________

Ocean Eye Institute has offered a copy of their Notice of Privacy upon request.

Signature ______________________________________ **Date** _______________________

PATIENT RESPONSIBLITY
FOR FOLLOW-UP CARE PLEDGE

I hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Patient Signature: ______________________________________ Date: _________________