ADVANCED EYE
CARE CENTER

Patient Information

Patient Name _____ Today's Date ____/____/____

Address _____

City _____ State _____ Zip _____

Home Number (_____) _____ Cell Number (_____) _____

Email _____

Date of Birth ____/____/____ Social Security Number _____

Pharmacy _____

Referred by _____ Family Doctor _____

Emergency Contact Information

Emergency Contact _____ Relationship to Patient _____

Phone Number (_____) _____

If you are the policy holder, please fill out only the bolded areas. Otherwise, please fill out every section.

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

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Financial Disclosure

FINANCIAL RESPONSIBILITY

Payment is expected at the time of service; those who are unable to provide payment on the day of their appointment will be rescheduled. Accepted methods of payment include cash, check, credit card, and debit card. We will file any insurance that is properly provided at the time of service. Although we will work with you during times of insurance transition, please understand that if we receive denials due to incorrect information or lapse/change of current insurance, you will be responsible for all charges.

REFRACTION SERVICE AND FEE

A necessary portion of a medical eye examination is a refraction as it determines the need for corrective eyeglasses, contact lenses and provides information when vision is blurry or increasingly changing. Medicare and most insurance companies do not cover this portion, so please be prepared to pay for the $68 refraction service in addition to your co-payment and/or deductible.

ACCEPTING INSURANCE

Our doctors are contracted with most medical insurance companies. If your insurance requires a referral to see a specialist, you must bring the referral to your appointment or verify that our office has received the referral. In addition, if your insurance company denies your claim due to a pre-existing clause, you will be responsible for any and all charges not covered by your insurance company. At the time of your visit, you will be expected to provide payment in the amount of any co-payment required by your insurance plan, any unmet annual deductible amount where appropriate, and any services that are not covered.

DISCLOSURE OF HEALTH INFORMATION

I consent to the disclosure of my health information to health professionals or entities outside of Advanced Eye Care Center for treatment, billing, and other healthcare operations purposes. This consent will remain in effect unless revoked.

I agree to the sharing of medical information with any family, friends, or others that I name below. If I do not agree, I will ask for a restriction request to limit sharing of my information. The sharing of medical information with family, friends or others does not give them permission to obtain copies of my medical record.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

ACKNOWLEDGMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient.

_____ Date ____/____/____

Signature of Patient or Authorized Person

_____

Relationship to Patient if the patient is not signing