ADVANCED EYE CARE CENTER

PATIENT UPDATE FORM

PERSONAL INFORMATION (PLEASE PRINT)

Name:____ Date:________________

Date of Birth: ________________ M: ____ F: ____ SS#:________________________

Mailing Address:____
Street City State Zip

Email:____

Please choose one preferred phone # for calls:

☐ Phone: ______________________ (cell) ☐ Phone: ______________________ (other)

COMPLETE IF UNDER 18 YEARS (Patient must be accompanied by an adult if under 18)

Father:____ Phone:________________

Address:____

Mother:____ Phone:________________

Address:____

INSURANCE INFORMATION

Marital Status: Single: ____ Married: ____ Widowed: ____ Divorced: ____

Primary Insurance: ____

Policy Holders Name: ________________________ Employer: ________________

DOB:______________ ID:______________________ Group:____________________

SecondaryInsurance:____

Policy Holders Name: ________________________ Employer: ________________

DOB:______________ ID:______________________ Group:____________________

Tertiary Insurance:____

Policy Holders Name: ________________________ Employer: ________________

DOB:______________ ID:______________________ Group:____________________

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: ______________________________ RELATIONSHIP: ____________________

PHONE NO. (INCLUDING AREA CODE) ______________________________________

MISCELLANEOUS

Where do you purchase glasses/contacts? ______________________________

Who do you use for your current pharmacy? ____________________ Location?______________

Who is your primary physician at this time? __________________________

PATIENT SIGNATURE: ____ **DATE:** ____________

ADVANCED EYE CARE CENTER

Do not sign this form until you have read and fully understand its contents

NOTIFICATIONS & AUTHORIZATIONS

Financial Policy

Our office is a participating provider for Medicare and most managed care plans. It is the patient's responsibility to provide their most current insurance card(s) and/or referrals at each visit. If you fail to provide your current insurance information, it may be necessary to reschedule your appointment or we will accept you as a "self-pay" patient and expect you to pay in full at the time of service and we will not file an insurance claim for that date of service.

Payment for any co-pay, deductible, or co-insurance is expected at the time of check-in. If your insurance denies coverage, or does not pay for certain services, you will be financially responsible for these fees. For services rendered to minor patients, we expect payment from the adult accompanying the patient at the time of service.

This office does not file claims for insurance companies that we are not participating providers for and we only file a maximum of two (2) insurance companies. All tertiary insurance policies are the responsibility of the patient. Please know we are not Medicaid providers and cannot file any insurance claims to Medicaid.

I have read and understand the patient office policies, including financial, procedures, Prism, Refraction, self-pay fees along with any co-payments, co-insurances, and/or deductibles will need to be paid at the time of service.

______________________________ Date: ____________________

Patient/Guardian/POA

Assignment of Benefits

I authorize Advanced Eye Care Center to release any information necessary to my insurance carrier(s) to process medical claims. I assign all insurance benefits to be paid directly to Advanced Eye Care Center/Lawrence A. Shafron, MD PA. (A photocopy of this assignment is to be considered as valid as the original.)

______________________________ Date: ____________________

Patient/Guardian/POA

General Consent for Treatment

I have requested medical services from Advanced Eye Care Center for myself and/or my dependent. I give permission to Advanced Eye Care Center to examine and treat myself and/or my dependent as they deem necessary.

______________________________ Date: ____________________

Patient/Guardian/POA

ADVANCED EYE CARE CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment but, in refusing, *we will not be allowed* to process your insurance claims.

Date: ______________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Advanced Eye Care Center**. A copy of this signed, dated document shall be as effective as the original.

______________________________ ______________________________

Please ***print*** your name Please ***sign*** your name

Last 4 digits of SS# ________________ DOB ____________________________

______________________________ ______________________________

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR MEDICAL INFORMATION:
(This includes step parents, grandparents and any other care takers who can have access to this patient's records):

Name: ___________________________ Relationship: ______________________

Name: ___________________________ Relationship: ______________________

Name: ___________________________ Relationship: ______________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY MEDICAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ❑ Cell Phone Confirmation
- ❑ Home Phone Confirmation
- ❑ Work Phone Confirmation
- ❑ Email Confirmation ____________________ Email
- ❑ U.S. Mail

I AUTHORIZE **INFORMATION ABOUT MY MEDICAL HEALTH** BE CONVEYED VIA:

- ❑ Message on Cell Phone
- ❑ Message on Home Phone
- ❑ Message on Work Phone
- ❑ Email Message
- ❑ U.S. Mail

❑ **Any of the above**

This Authorization will remain in effect for one year from the date of signature unless changed by patient.

____________________________ ____________

Patient/Guardian/POA Date

____________________________ ____________

Patient/Guardian/POA Date

____________________________ ____________

Patient/Guardian/POA Date

____________________________ ____________

Patient/Guardian/POA Date