

Patient Information

Patient Name _____ Account # _____	Home Telephone # _____ Work Telephone # _____ Cell Telephone # _____
Social Security Number _____	
Address _____	Patient Sex <input type="checkbox"/> Male <input type="checkbox"/> female
City, State & Zip Code _____	Date of Birth _____ Age _____
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact Name & Phone _____ Relationship to Patient: _____ _____
Referring Physician: _____ Family Physician: _____	Email Address (please print) _____ Married <input type="checkbox"/> Single <input type="checkbox"/> Other <input type="checkbox"/> Spouse's Name _____

Insurance Company Information

Primary Insurance Company Name _____	Secondary Insurance Company Name _____
Address, City, State & Zip _____	Address, City, State & Zip _____
Policy Holder _____ Date of Birth _____	Policy Holder _____ Date of Birth _____
Policy Holder Employer _____ Policy Holder SSN _____	Policy Holder Employer _____ Policy Holder SSN _____
Policy Number _____ Group Number _____	Policy Number _____ Group Number _____
Relationship to the Patient (check one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other	Relationship to the Patient (check one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other

Financially Responsible Person (if different from above)

Full Name _____ Address _____ City, State & Zip Code _____ Date of Birth _____	Social Security Number _____ Home Telephone # _____ Work Telephone # _____ Cell Telephone # _____
Employer Name _____	Relationship to the Patient (check one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other

Date Reviewed _____ Initials _____

<p>Race of Patient:</p> <p><input type="checkbox"/> American Indian/ Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black/ African American</p> <p><input type="checkbox"/> Native Hawaiian/ Other Pacific Islander</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Declined to answer</p> <p><input type="checkbox"/> Hispanic Origin</p> <p><input type="checkbox"/> Non Hispanic Origin</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Declined to answer</p>	<p>Preferred Language of Patient:</p> <p><input type="checkbox"/> English <input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other _____</p> <p style="text-align: center;">In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.</p>
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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 Coastal Eye Associates surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature _____ Date _____

Medicare Patients

Medicare does not pay for all of your health costs and only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does NOT mean that you should not receive it. Your doctor may recommend this item or service even though it is not a covered item.

Signature _____ Date _____

Patient Acknowledgement Form

Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information (PHI) about you. It applies to the information and records we have about your health, health status, and the health care and services you receive at this office. The date of the most recent Notice will appear in the upper right hand corner. By signing this form, you are simply acknowledging that you have been offered or have received a copy of our "Notice of Privacy Practices".

Signature _____ Date _____

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but it is **NOT** a covered service by Medicare or most insurance plans. Our office fee for refraction is **\$35.00** and this fee is collected in the addition to the patient's co-pay.

Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refractive fee.

Signature _____ Date _____