Coastal Eye Associates

Patient Information

Account # _____ **Patient Name** **Social Security Number**	**Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____
Address	**Patient Sex** ☐ **Male** ☐ **Female**
City, State & Zip Code	**Date of Birth** _____ **Age** _____
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone** _____ **Relationship to Patient:** _____
Referring Physician: _____ **Family Physician:** _____	**Email Address (please print)** _____ **Married** ☐ **Single** ☐ **Other** ☐ **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) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ 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)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed _____ Initials _____

Race of Patient:

- ☐ **American Indian/ Alaskan Native**
- ☐ **Asian**
- ☐ **Black/ African American**
- ☐ **Native Hawaiian/ Other Pacific Islander**
- ☐ **White**
- ☐ **Unknown**
- ☐ **Declined to answer**

- ☐ **Hispanic Origin**
- ☐ **Non Hispanic Origin**
- ☐ **Unknown**
- ☐ **Declined to answer**

Preferred Language of Patient:

☐ **English** ☐ **Spanish**

☐ **Other** _____

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.

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 **$45.00** and this fee is collected in the addition to the patient's co-pay.

Acknowlegement

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 _____

Coastal Eye Associates

HIPAA Confidentiality Questionnaire

Patient Name:_____ Chart#_____
DOB:_____

In order to comply with HIPAA guidelines, it is necessary for you to complete the following information:

List family and/or other people authorized to pick up your written prescriptions, test results, any forms or sample medications. This also includes whom we may inform about your general medical condition, diagnosis, test results and treatment plan.

Name:_____ Relation:_____
Phone:_____

Name:_____ Relation:_____
Phone:_____

May we leave confidential (medical and billing information) messages on your home answering machine or voicemail? Y N
May we leave confidential (medical and billing information) messages on your cell phone/work voicemail? Y N

I understand that this consent will remain in effect until revoked in writing by myself or my legal guardian/parent.

Signature:_____ Relation:_____
Date:_____

*****PLEASE NOTE*****
If you fail to notify our office in writing that you would like to have an individual removed from any of the above, that person WILL be able to obtain information about your care from our office.