Patient Name:____ Today's Date: ________________________
Last First Middle

Home Address____

City____State____________ Zip Code__________________

Home Phone___________________ Cell Phone___________________ E-mail address______________________________________

Preferred method of contact: Phone______Text______E- mail______ Marital Status Single Married Divorced Widowed

Social Security Number______________________________ Date of Birth_________________ Age _____ Gender M F

Employer/Parent's Employer___________________________________Occupation_________________________________

Work Address____Work Phone: ___________________________________

City____State_________Zip Code________________________

Spouse name (Parent name if minor) ______________________________Spouse/Parent Work Phone____________________________

Person to notify in case of emergency (other than spouse) ____

Phone number (s) ____Relationship________________________________

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

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Alabama Eye & Cataract Center, P.C. to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_______________________________________ ____________________________
Patient's signature **Today's date**

PHARMACY INFORMATION:

____________________________	______________________________	____________	____	(___) _____________
Preferred Pharmacy	Street Address	City	State	Phone #

PHYSICIAN INFORMATION:

____________________________	______________________________	____________	____	(___) _____________
Referring Physician	Street Address	City	State	Phone #
____________________________	______________________________	____________	____	(___) _____________
Primary Care Physician	Street Address	City	State	Phone #
____________________________	______________________________	____________	____	(___) _____________
Other Physician (Name & Specialty)	Street Address	City	State	Phone #

Responsible Party Information: (If not patient)

Name: ____

Mailing Address: ____

Phone #: ____ Relationship to Patient: _________________

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of **Alabama Eye & Cataract & Cataract Center, p.c.** to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, and friend)

Name of Person or Entity:	**Relationship:**

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

____ Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

____ Signature of the Patient or Patient Representative

I request that payment of authorized Medicare, Medicaid and/or Commercial insurance carrier benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by the provider of service and/or supplier. I authorize the release of my medical information to the Centers for Medicare and Medicaid Services and/or Commercial insurance carriers and its agents, which may be needed to determine these benefits payable for related service. LIFETIME AUTHORIZATION

____ Signature of the Patient or Patient Representative

Refraction Services and Fees

A refraction is the process of determining your best corrected vision and if there is a need *for corrective* eyeglasses or contact lenses. It is an essential part of the eye exam and it necessary to write a prescription for glasses or contact lenses.

A refraction is also needed for any patient that is complaining of blurred vision or has had any vision changes.

A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

We will NOT file the charge for a refraction with a health insurance unless we know that your plan covers the refraction charge.

Our office fee for a refraction is $30.00, and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

We cannot file Insurance on both medical and routine vision plan for the same visit.

O I agree to pay the $30 refraction fee that my medical insurance does not cover.

O I decline to have refraction performed today.

Patient's Name (printed) Date

Patient's Signature (or legal responsible party) Relationship to patient