ALABAMA EYE & CATARACT CENTER p.c.

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 |

_____ _____

**Patient's signature** **Today's date**

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**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 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

ALABAMA EYE & CATARACT CENTER p.c.

# 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 $40.00, 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.

0 I agree to pay the $40 refraction fee that my medical insurance does not cover.

0 I decline to have refraction performed today.

Patient's Name (printed) Date

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

I certify that I (or my dependent) have insurance coverage and agree to have insurance payments made directly to Alabama Eye & Cataract Center, P.C. and to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event 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.

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.

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