THE EYE GROUP SC

PATIENT INFORMATION

Patient Name_____

Address_____

City_____ State_____ Zip_____

SS#_____

EMAIL_____

Sex M F Age_____ Birthdate_____

Married Widowed Single Minor

Separated Divorced

Occupation_____

Patient Employer/School _____

Responsible Party Name_____

DOB_____ Relationship to patient_____

Whom may we thank for referring you?

PHONE NUMBERS

Home ( )_____

Cell ( ) _____

Work ( ) _____

Best place to reach you_____

Name of policy holder on insurance

_____

Relationship to patient_____

Policy holder's employer_____

DOB_____ SS#_____

CONTACT LENS PATIENTS

Contact lenses are considered a medical device, therefore, the fit of the lens, health of your eye and prescription must be evaluated yearly. Additional tests and measurements are performed during your eye exam. Fees for this service are determined by the type of contact, prescription and whether this is a new or existing exam. I understand and agree to this service.

_____

Initials Date

AUTHORIZATIONS

PLEASE PROVIDE THE FRONT DESK WITH CURRENT INSURANCE CARDS FOR SUBMISSION OF SERVICES.

NO INSURANCE INFORMATION PROVIDED CHARGES WILL BE PATIENTS RESPONSIBILITY

ALL Insurance authorization and release

I certify that I have coverage and assign directly to The Eye Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Eye Group may use my healthcare information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determine benefits or the benefits payable for related services.

**Medicare patients—Medicare does not cover refraction fees and I agree to pay for this service. $36.00

I agree and been informed of the HIPPA Notice of Privacy Rights.

_____

Signature (Patient,Parent, Guardian or Legal Representative)

_____

Printed Name Date

RETINAL IMAGING

The Eye Group doctors perform ROUTINE images of your eyes yearly. Only if a MEDICAL condition exists will charges be submitted to your MEDICAL insurance. SOME routine vision insurance plans offer this service with a copay.

Our charge is $ 40.00