EASTERN MEDICAL EYE CENTER

PATIENT INFORMATION

Patient Name_____ Date of Birth:_____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Marital Status: Single Married Divorced Widowed Gender: Male Female

Social Security # _____ Race_____

EMAIL_____

Employer _____ Work Phone _____

Emergency Contact_____ Phone_____ Relationship_____

Responsible Party_____ Phone_____ Relationship_____

PHARMACY_____ City_____ Phone_____

PRIMARY INSURANCE

COMPANY_____

CONTRACT#_____

GROUP#_____

INSURED'S NAME_____

INSURED DOB_____

SECONDARY INSURANCE

COMPANY _____

CONTRACT#_____

GROUP#_____

INSURED'S NAME _____

INSURED DOB _____

INSURANCE REFERRALS

I understand that if my insurance should require a referral to see the doctor today or at any time during my treatment, it is my responsibility to provide your office with the referral. If my insurance company denies payment – due to no referral – I agree to pay Eastern Medical Eye Center in full for any charges incurred during my visit.

PATIENT/GAURDIAN SIGNATURE: _____ DATE: _____

INSURANCE RELEASE INFORMATION

I hereby authorize the practice of Eastern Medical Eye Center to release any information concerning my medical condition, treatment, and prognosis to my insurance carriers and other treatment physicians.

I hereby authorize Eastern Medical Eye Center to furnish any information concerning my medical condition, treatment, and prognosis to my insurance carriers and other treatment physicians. I hereby assign Eastern Medical Eye Center all payments for medical and/or surgical services rendered to me or my dependents due or received from third-party providers. I agree to be responsible for any amount not covered by my insurance or other providers. I agree to pay all costs of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection), and interest on the unpaid balance at the rate of ten (10%) percent per annum. I hereby waiver all rights of exemption under the U.S. and Alabama Constitutions and the laws of the State of Alabama. I authorize treatment by

I hereby assign to Eastern Medical Eye Center - Insurance or other third-party benefits available for health care services provided to me. I understand that Eastern Medical Eye Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Eastern Medical Eye Center I agree to forward to Eastern Medical Eye Center all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

PATIENT/GAURDIAN SIGNATURE_____ DATE_____

Eastern Medical Eye Center

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For instance, results of laboratory tests and procedures kept in your medical record will be available to all health professionals who may provide treatment to you or who may be consulted by staff members relating to your care.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information regarding dates of service, the services provided, and the medical conditions being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Eastern Medical Eye Center Budgeting and financial reporting are examples of such usage.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For instance, we are required to report certain communicable diseases to the state's public health department.

Research. We may access your health information for research purposes; this may include Institutional Review, Board-approved and regulated clinical studies as well as retrospective reviews of patient outcomes.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you wish to change a previous authorization, you may to do so by submitting to our office a written revocation of that previous authorization. Please be aware that your decision to revoke the previous authorization will not affect or undo any prior use or disclosure of information associated with the initial authorization.

Additional uses of information. Appointment reminders. Our staff will use your health information to remind you of pending appointments.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or on other health-related goods and services that you find to be of interest.

Acknowledgement of Receipt of Notice of Privacy Practices

Eastern Medical Eye Center

I have received a copy of the above described Notice of Privacy Practice form, and I understand the rights of privacy as afforded me therein. Furthermore, I understand that reserves the right to modify the privacy practices outlined in the notice.

_____

Name of Patient (Print or Type)

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Patient Representative **Relationship to Patient**

(Required if the patient is a minor or an adult who is unable to sign this form.)

EASTERN MEDICAL EYE CENTER

John S. Morgan, M.D.

Jeff Chaiprakob, M.D.

MAIN OFFICE
St. Vincent's East
52 Medical Park East Dr. • Suite 211
Birmingham, AL 35235
(205) 838-3696

www.easternmedeye.com

ONEONTA
St. Vincent's Blount
Professional Building • Suite 103
150 Gilbreath Drive • Oneonta, AL 35121
(205) 274-4200

I hereby authorize Eastern Medical Eye Center to furnish any information concerning my medical condition, treatment prognosis, test results, and appointment dates and times to the following individuals:

Name_____ **Phone**_____ **Relationship**_____

Name_____ **Phone**_____ **Relationship**_____

Name_____ **Phone**_____ **Relationship**_____

I do not want my information released to anyone_____

I, _____ **understand that you will be transmitting my medical records electronically to my referring doctor, ect... and I authorize you to do so. If another party receives them in error, I absolve Eastern Medical Eye Center of any and all liability relating to such submissions of said records.**

Signature_____ **Date**_____

REFRACTION SERVICE AND FEE

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover refractions or routine eye examinations. Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate **vision plan** that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for refraction is **$35.00** 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.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient 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 and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_____ I understand that I will be responsible for the $35.00 refraction fee and request to have the refraction performed as part of my examination.

_____ I do not wish to have the refraction performed and understand that I will not receive a new prescription if I do not have the refraction done at the time of visit.

_____ _____

Patient Signature (Parent for Minor) Date