Confidential Patient Information

Welcome, and thank you for choosing our office for you eye care needs. Please take time to complete this form. If you have any questions or concerns, do no hesitate to ask for assistance.

PATIENT INFORMATION

Name: (Mr., Mrs., Ms., Dr.) _____ Sex: M F

LAST FIRST MI

Date of Birth: _____ Social Security #: _____-_____-_____ Referred by:_____

Home Address:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ Texting Yes or No

Email Address (For notification purposes): __

Employer: _____ Occupation: _____ Pharmacy Preference: _____

Vision Insurance: _____ Primary Insured's Name: _____ Insured's Date of Birth:_____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Please list family members who are currently patients of ours:_____

CONSENT AND AUTHORIZATION

I acknowledge and understand that I am responsible for all of the charges for the services and materials rendered to me or to the person named above for which I am responsible. I further understand that the billing to my insurance company or Medicare in no way relieves me of responsibility for payments, co-payments or payments for non-covered services and materials due to Eye & Vision Care. I understand that delinquent balances are subject to finances charges and that the account may be sent to a collections agency. I hereby authorize my insurance company to pay proceeds for any benefits otherwise due to me direct to Eye & Vision Care.

_____ ***Initials***

I authorize the release of any medical information, by electronic or other means, to process insurance claims, or for use in medical research. I understand by signing this form I am allowing my medical information to be released to my insurance company primary care physician and specialists for the purpose of health care operations or medical research, as described in our *Notice of Privacy Practices.* I understand that I may revoke this consent by written request at any time.

_____***Initials***

ASSIGNMENT OF MEDICARE BENEFITS (*if applicable*)

Eye and Vision Care Optometric Group is a Medicare participating provider. Therefore, we will bill Medicare directly. Medicare will send payment directly to our office. This payment will consist of **80% of the Medicare Part B approved Charges**. I understand that I will be responsible for the yearly deductible and **20% of approved charges**. i have been informed that **NOT** all services are covered by Medicare (e.g. eye refractions). My signature verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

_____ ***Initials***

_____ _____

Patient's Signature or Authorized Representative Date

EYE & VISION CARE OF SANTA BARBARA

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