Eyecare Center of Madison

302 North Harth Ave
Madison, SD 57042
Phone: 605.256.6911
Fax: 605.256.9017

Patient Information Form

Legal Name:_____Middle Initial:_____ Last Name:_____

Preferred Name/Nickname:_____

Date of Birth:_____ Gender: Male ☐ Female ☐ Race:_____

Address_____

Cell phone:_____ Home phone:_____

Email Address:_____

Preferred Communication: Text ☐ Email ☐ Voice message ☐

Primary Care Provider:_____ Clinic:_____

Employer Information

Occupation/Job Title:_____ Employer:_____

School:_____ Grade/Major:_____

Responsible Party

Same as Patient ☐ Use as Emergency Contact ☐

Name_____ Last 4 of SS #:_____

Address (if different than patient)_____

Phone:_____ Email:_____ DOB:_____

To help the doctor and staff serve you effectively, please indicate what you would like to accomplish during your visit:

☐ Update frames and/or Lenses
☐ Wearing/considering Contact Lenses
☐ Interested in specialty eyewear (sun/computer)
☐ Want Information about corrective eye surgery
☐ Evaluation for a specific condition or disease_____

Approx. Date of your last Professional Eye Exam_____ Eye Doctor_____

How did you hear about us?

☐ Online ☐ Newspaper ☐ Location ☐ Other Doctor_____
☐ Friend or Family member previously seen in our office_____

Medical Insurance Carrier: _____

Vision/Optical Plan:_____

Except for amounts covered by "participating" insurance plans that reimburse our office directly, payment for services is expected on the date of service. ***A 50% prompt pay discount is applied to professional services paid at the time of service.*** We also offer Care Credit no-interest monthly payment financing. (application and online approval available at our office). Please indicate your preference for settling your account:

☐ Check ☐ Cash ☐ Credit Card ☐ Care Credit

Signature (patient or responsible party):_____ **Date:** _____

Continue on Reverse Side

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this notice upon request. A copy is available to view at the front desk.

I hearby acnowledge the receipt of the notices of privacy practices given to me:

Initials:_____

Authorization for release of Records to Specified Persons

The following person(s) may receive information about me from my medical records:

Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____
This authorization will remain in effect until canceled by me.

Initials:_____

Medicare Agreement

I have been notified that medicare may not pay in full for services provided for the reasons stated below. I understand that, by law, the doctor is obligated to bill me for applicable deductables and co-payments.

Medicare may pay for the "medical" portion of the exam, the **refraction** procedure is **NEVER** a "covered" service. We are required by Medicare to allocate a seperate charge to this portion of the exam and this charge is *always* the patients responsibility.
Medicare supplement plans may or may not pay for the deductable and or co-payments. Every supplement has unique payment policies.

Initials:_____

Insurance Authorization/Assignment of Benefits

I hereby authorize The Eyecare Center of Madison to furnish to my insurance carrier any information needed to determine benefits payable for services rendered to myself or my dependents.
I request that payment of these benefits be made on my behalf directly to the Eyecare Center of Madison.
I understand that I am responsible for any amount not covered by my insurance.

Initials:_____

Signature_____ **Date**_____

Authorized Representative (relationship to Patient)_____