CENTER FOR EXCELLENCE IN EYE CARE

PATIENT INFORMATION

DATE (FECHA) _____ **ACCOUNT #** _____

NAME (NOMBRE): _____ **SEX** (SEXO) _____

MARITAL STATUS (ESTADO CIVIL) _____ **DATE OF BIRTH** (FECHA DE NACIMIENTO) _____ **AGE** (EDAD) _____

SOCIAL SECURITY NUMBER (NUMERO DE SEGURO SOCIAL) _____

PHONE (TELEFONO) **HOME** (CASA) _____ **WORK** (TRABAJO) _____ **CELL** (CELULAR) _____

ADDRESS (DIRECCION) _____

CITY (CIUDAD) _____ **STATE** (ESTADO) _____ **ZIP CODE** (CODIGO POSTAL) _____

PERSON RESPONSIBLE FOR BILL _____
(PERSONA RESPONSABLE POR LA CUENTA)

OCCUPATION (OCUPACION) _____ **WORK PHONE** (TELEFONO DEL TRABAJO) _____

EMPLOYER (EMPLEADOR) _____

ADDRESS (DIRECCION) _____

E-MAIL ADDRESS (DIRECION ELECTRONICA) _____

PATIENT'S SPOUSE OR PARENT (IF MINOR) _____
(ESPOSO (A) PADRES (SI ES MENOR)

REFERRED BY (REFERIDO POR) _____ **PHONE** (TELEFONO) _____

FAMILY PHYSICIAN (MEDICO FAMILIAR) _____ **PHONE** (TELEFONO) _____

INSURANCE CARRIER NAME (NOMBRE DEL SEGURO) _____

NAME AND SOCIAL SECURITY NUMBER OF THE SUBSCRIBER _____
(NOMBRE Y NUMERO DE SEGURO DEL ASEGURADO)

ALLERGIES (ALERGIAS) _____

PHARMACY NAME _____ **ADDRESS** _____ **PHONE** _____
(NOMBRE DE LA FARMACIA) (DIRECCION) (TELEFONO)

EMERGENCY CONTACT: NAME _____ **PHONE** _____ **RELATIONSHIP** _____

MAY WE LEAVE A MESSAGE IN YOUR VOICEMAIL OR ON YOUR ANSWERING MACHINE? **N/A** _____ **YES** _____ **NO** _____
(PODEMOS DEJARLE UN MENSAJE EN SU MAQUINA TELEFONICA O CORRERO ELECTRONICO)

MAY WE CONTACT YOU AT WORK? **N/A** _____ **YES** _____ **NO** _____
(PODEMOS LLAMARLE AL TRABAJO?)

MAY WE DISCUSS MEDICAL INFORMATION ABOUT YOU WITH YOUR SPOUSE OR FAMILY MEMEBER? **N/A** _____ **YES** _____ **NO** _____
(NOS AUTORIZA A DISCUTIR INFORMACION MEDIA CON SU ESPOSO/ A - O ALGUN FAMILIAR?)

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to the Center For Excellence in Eye Care for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. The undersigned agrees, whether he/she signs as a parent, spouse, guardian, or the patient that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account. 10% of the outstanding amount will be added to the account to cover collection fees. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.
(El (La) suscrito (a) autoriza que, toda la informacion médica necesaria para procesar cualquiera de mis reclamos a mi compañia de seguros sea puesta a disposicion de ésta. Asi mismo autorizo el pago de mis beneficios médicos directamente al Center For Excellence in Eye Care. Entiendo y accepeto que, independiente de mi condicion de asegurado (a), soy totalmente responsable di mi cuenta por los servicios profesionales recibidos en este centro. Si acaso esta cuenta fuese enviada a un servicio de cobranzas, todos los gastos que se originen de este recurso legal son tambien de mi reponsabilidad). El/la suscrito/a consiente que al firmar como padre, esposo/a, fiador, guardian o paciente, asume la responsabilidad y obligación por cualquier balance pendiente que derive a causa de tratamiento médico a dicho paciente. 10% de la cantidad pendiente se añidara a la cuenta para cubrir los gastos de recolección. En caso de que la cuenta fuese referida a un abogado, el/la suscrito/a pagara dichas cuentas legales y asumira costos de colección.

SIGNATURE (FIRMA) _____ **NAME (NOMBRE)** _____
PLEASE PRINT NAME (por favor use letra de molde)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record # _____

Date of Visit: _____

My signature on this form ackowledges that I have received of copy of the Center For Excellence in Eye Care's Notice of Privacy Practice.

- The Center For Excellence in Eye Care has the right to change the terms of of the Notice at any time but if it does, it must post the new Notice in the waiting room and give me a copy if I request one.
- I understand that the Notice explains some of the ways in which the Center For Excellence in Eye Care may use or disclose my health information.
- The Notice also explains my rights with respect to my health information.

I am the patient or I am authorized to act on behalf of the patient for the reason described below.

Date: _____ _____
Patient's Signature

Date: _____ _____
Signature of Patient's Representative if Patient is unable to sign

_____
Relationship of Patient's Representative to Patient

TO BE COMPLETED BY HEALTH CARE PERSONNEL IF FORM WAS NOT SIGNED

1. Was the patient provided with a copy of the Center For Excellence in Eye Care's Notice of Privacy Practices? _____ YES _____ NO

2. Briefly describe the efforts made to obtain the patient's Acknowledgement of Receipt of the Notice and explain why the patient was not able or willing to sign this form:

_____

_____

Date _____ _____
Signature of Health Care Personnel

CENTER
FOR
EXCELLENCE
IN EYE CARE

TO OUR PATIENTS ABOUT YOUR INSURANCE

The health insurance policy that you have is a personal contract that you have with your insurance company. We are simply physicians, and we do our very best to provide excellent service in a caring environment. We deserve to be paid for this service regardless of whether your insurance covers this or not. We are not employed by your company, nor do we make policy decisions for your company. Many patients are confused by their insurance company's coverage of **vision care.** Many policies will only cover a "medical diagnosis". This means that if the doctor finds something medically wrong at the time of his examination, some or all of the cost of this examination may be covered by the insurance company, as long as your company considers it "medical". However, if the examination is **normal** or has a "vision" diagnosis such as myopia, amblyopia, hyperopia, astigmatism, headaches or asthenopia, your insurance will not pay for your examination. Since we have no way of knowing in advance what the doctor will find, we cannot tell you in advance whether your visit will be covered or not, and you may be responsible for the visit.

Some companies require that you have a referral from your **PRIMARY PHYSICIAN**, and it is your responsibility to obtain that referral. If you wish to be seen without a referral, you will be responsible for payment at the time of your visit. It is the patient's responsibility to know and understand his/her own individual policy. We are involved with so many different companies that we cannot be interpreters of the policies for each patient. Thank you for you cooperation and patience.

We have been informed by all insurance companies, including Medicare, that **REFRACTIONS** (the examination to determine the prescription for glasses) is a **"non-covered"** service that will not be reimbursed to the physician or the patient.

Even though we are "participating providers", if a refraction is either necessary or requested by the patient, a charge in the amount of 45.00 service is therefore payable at the time of that examination, and we cannot submit this portion of the charge to your insurance company or Medicare.

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to the Center For Excellence in Eye Care for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. The undersigned agrees, whether he/she signs as a parent, spouse, guardian, or the patient that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND

_____

Patient Signature and / or Legal Guardian if minor

_____

Date