PATIENT INFORMATION

Form 1

NAME _____ MALE ☐ FEMALE ☐ _____

LAST FIRST MIDDLE INITIAL GENDER DATE OF BIRTH

ADDRESS _____ _____ _____

STREET CITY STATE ZIP CODE

HOME PHONE # _____ WORK # _____ _____

CELL PHONE NUMBER _____ MARITAL STATUS: _____

SOCIAL SECURITY NUMBER _____ PHARMACY _____

FAMILY DOCTOR _____ # _____

EMERGENCY CONTACT _____ PHONE # _____

EMAIL ADDRESS _____

May we contact you by email regarding your care at North Coast Ophthalmology? Yes ☐ No ☐

INSURANCE INFORMATION

PRIMARY: _____ _____

SECONDARY: _____ _____

PERSON RESPONSIBLE FOR PAYMENT

NAME _____ _____

LAST FIRST MIDDLE INITIAL DATE OF BIRTH

ADDRESS _____ _____ _____

STREET CITY STATE ZIP CODE

_____ _____

SOCIAL SECURITY # HOME PHONE # WK PHONE # RELATIONSHIP TO PATIENT

AUTHORIZATION FOR INSURANCE OR PAYMENT

I authorize the release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits to North Coast Ophthalmology. **I am financially responsible for all services provided by North Coast Ophthalmology (NCO) to me or my dependents**. If NCO is not a participating provider in my insurance plan, I understand that payment is required at the time of service. If my insurance requiers a referral from my promary care physician, I will provide the referral at the time of service

REFRACTION FEE & OTHER FEES

A **refraction** is a test to obtain your best corrected vision to determine the need for glasses, contacts, surgery and/or medician. Most medical insurance plans, including Medicare, do not cover refractions. Our office may collect the **refraction fee of $35 along with any co-payment at the time of service.** Any additional testing m ay not e covered by your insurance plan. Fees are subject to change.

RETURNED CHECK FEES

A minimum charge of $25 will be made for NSF or returned checks. If a third party is involved to resolve payment for services provided by the North Coast Ophthalmology, I agree to be responsible for collection agency fees, attorney fees, court costs, interest or other charges incurred, as allowed by law.

STATEMENT OF NOTICE OF PRIVACY PRACTICES/HIPAA

Your medical information is personal to you and by law the North Coast Ophthalmology is required to make sure that it is kept private.

You may obtain a copy of our "Notice of Privacy Practice" and today's visit summary by request.

I have been offered a clinical summary of today's visit

SIGNATURE _____ **DATE** _____

Thank you for choosing the North Coast Ophthalmology.

RV 10/2012