The EyeCenter

Surgeons and Associates, L.L.C.

401 Meridian Street, Suite 200
Huntsville, Alabama 35801

Dr. Walter J. Hubickey

Director of Refractive Surgery

Patient Information

Today's Date: _____

How did you hear of Dr. Hubickey?

❑ **News Ad** ❑ **Magazine** ❑ **Billboard** ❑ **Website** ❑ **Face Book**
❑ **Friend** ❑ **Other:** _____

Please note: Laser Vision Correction evaluation fees are due at time of service. Laser Vision Correction Surgery fees are due one week prior to surgery.

Patient Name (last, first, middle initial)		Date of Birth	Sex	Daytime Phone
Street Address	City	State	Zip	Cell Phone
Referring Physician	Family Physician			Home Phone
Email Address				Social Security Number
Single ( ) Married ( ) Widowed ( ) Divorced ( ) Full-time Student ( ) Part-time Student ( )				
Employer's Name	Street Address			Business Phone Number
City	State		Zip	
Spouse's Name (last, first, middle initial)	Work Phone		Daytime Phone	
Emergency Contact (who doesn't live with you)	Relationship		Phone Number	

Please complete the information below in the event we would need to file your insurance for any medical necessity:

Insurance Company: _____ Group Number: _____

Insured Name: _____ Contract/ID Number: _____

Insured Birthday: _____ Relationship to Patient: _____

PLEASE COMPLETE BACK OF FORM

Patient Billing/Payment Authorization

Each patient is responsible for obtaining a referral if one is required by your insurance carrier. It is the patient's responsibility to ensure that The Eye Center is a participating provider with their insurance carrier. If The Eye Center is a participating provider with the patient's insurance carrier, we will file your claim for your office visit or surgery and allow 45 days for payment in full. If you do not have insurance, do not have a referral for the service date or we are not a participating provider with your insurance carrier, payment is expected at the time services are rendered.

Co-payments and non-covered fees, such as refraction fees, are the responsibility of the patient and are due at the time of service.

A refraction is a reading to determine your best corrected vision. Insurance does not usually cover the cost of refractions.

It is the policy of The Eye Center to collect all payments in full at the time of service. If your visit is a result of an injury or accident involving a lawsuit, (excluding workers comp), we will gladly provide receipts for all services rendered for your reimbursement.

Extended Patient Signature Authorization

Authorization for The Eye Center, 401 Meridian Street, Huntsville, AL 35801

I request that payment of authorization Medicare benefits be made either to me or on my behalf to The Eye Center for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of (*patients insurance company/companies on file*) benefits be made directly to The Eye Center.

By signing below, I understand that routine vision care, refraction fees, diagnostic testing, and co-pays may not be covered by my insurance carrier and I am responsible for these services at the time they are rendered.

*

_____ _____

Signature of beneficiary or person signing for beneficiary **Date signed**