

The  
**EyeCenter**

Surgeons & Associates, LLC



Eye Center Pediatrics

**Julie K. Calderwood, M.D**  
**Pediatric Specialist**

Servis 1<sup>st</sup> Bank Building  
401 Meridian Street, Suite 300  
Huntsville, AL 35801  
Phone 256/705-3937

*We are so excited to meet you!*

*We want this visit for you to be as pleasant and easy as possible,  
so here are a few things to tell your parent(s) or guardian(s).*

- Your appointment is going to last about 2-3 hours, so make sure your parent(s) or guardian(s) are prepared. We have a playroom and lots of movies to help keep you entertained.
- It is important for Dr. Calderwood and her staff to give you their undivided attention. We request that only you and your parent(s) or guardian(s) are present for your appointment.
- If you wear glasses or contacts, please make sure you remind your parent(s) or guardian(s) to bring them to your appointment.
- If you have ever seen another eye doctor or you are being referred for a specific problem, please make sure to tell your parent(s) or guardian(s) to bring the records to your appointment or to have them sent to our office before your appointment with Dr. Calderwood. This will be very helpful for your exam.
- If you have any major medical problems or your parent(s) or guardian(s) know you're going to require extra time, please have them call us and let us know so we can make accommodations for you!

Please have your parent(s) or guardian(s) call us if they have any questions!

DATE: \_\_\_\_\_



ACCT #: \_\_\_\_\_

### PATIENT DEMOGRAPHIC INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)				DATE OF BIRTH	
GENDER	ADDRESS		CITY	STATE	ZIP
HOME PHONE		WORK PHONE		CELL PHONE	
SOCIAL SECURITY #			EMAIL ADDRESS		
REFERRING PHYSICIAN			PRIMARY CARE PHYSICIAN		
SPOUSE NAME			DATE OF BIRTH		SSN
ARE YOU (the patient) OF HISPANIC OR LATINO DESCENT? Y N			RACE: white black hispanic asian other		
EMERGENCY CONTACT			RELATIONSHIP		PHONE#
MAY WE CONTACT YOU AT THE PHONE NUMBER, ADDRESS AND/OR EMAIL ADDRESS GIVEN ABOVE? Y N					
IF NOT HOW MAY WE CONTACT YOU? _____					
<b>EMPLOYER INFORMATION</b>					
EMPLOYER'S NAME				BUSINESS PHONE	
SPOUSE'S EMPLOYER				BUSINESS PHONE	
<b>IF PATIENT IS A CHILD, PLEASE COMPLETE</b>					
NAME OF PARENT WITH WHOM CHILD RESIDES				DOB	SSN
ADDRESS			CITY	STATE	ZIP
HOME PHONE		EMPLOYER'S NAME		WORK PHONE	
OTHER PARENT			DATE OF BIRTH		SSN
ADDRESS			CITY	STATE	ZIP
HOME PHONE		EMPLOYER'S NAME		WORK PHONE	
<b>IF A PARENT IS UNABLE TO ATTEND A CHILD'S APPOINTMENT WHO MAY ACCOMPANY THE PATIENT</b>					
NAME			PHONE #		SSN
NAME			PHONE #		SSN
<b>INSURANCE INFORMATION</b>					
DO YOU HAVE <b>MEDICAID</b> INSURANCE? Y N					
<b>PRIMARY INSURANCE</b>			<b>DO YOU HAVE A SECONDARY INSURANCE? Y N</b>		
INSURANCE COMPANY			INSURANCE COMPANY		
ID#	GROUP#		ID#	GROUP#	
GUARANTOR OF INSURANCE			GUARANTOR OF INSURED		
DATE OF BIRTH		SSN	DATE OF BIRTH		SSN
RELATIONSHIP TO INSURED			RELATIONSHIP TO INSURED		

**PLEASE READ AND SIGN BACK OF FORM**

Revised Date 09/23/13

**BILLING AND PAYMENT AUTHORIZATION  
AUTHORIZATION FOR THE EYE CENTER SURGEONS & ASSOCIATES, LLC**

By signing below, I authorize The Eye Center to request payment, made directly to The Eye Center and file an insurance claim based on insurance information I provide to include Medicare, Medicare Supplement Plans, and Medicaid Plans. I agree to provide the most updated insurance information with allowing a copy of the card to be on file. 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 benefits or the benefits payable for related services.

By signing below, I understand the following:

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 we will file the claim for your office visit or surgery, please 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, payment is expected at the time services are rendered. Co-payments and non-covered fees, such as refraction fees (up to \$35.00) are the responsibility of the patient and are due at the time of service. Patients may be subject to a \$10.00 fee for co-payments not paid the same date of service. Any accounts subject to collections due to non-payment will accrue a 15% fee added to remaining balance.

SIGNATURE **X** \_\_\_\_\_ DATE **X** \_\_\_\_\_

**RESTRICTIONS TO THE USE AND/OR DISCLOSURE OF PERSONAL PROTECTED HEALTH INFORMATION**

If you choose to restrict the use and/or disclosure of your protected health information you can list the restriction(s) below:

\_\_\_\_\_

This authorization permits The Eye Center to send the protected health information ONLY to this address or fax number. Any other address or fax number is not permitted by this authorization.

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on the authorization or, if applicable, during contestability period. In order for the revocation of the authorization to be effective.

The Eye Center must receive that revocation in writing. This revocation must include:

- The patient's name, address and date of birth
- The effective date of the authorization, and the recipients of the protected health information according to this authorization
- The patient's desire to revoke the authorization
- The date of the revocation, and the patient's signature

The Eye Center will accept written revocations of the authorization via U.S. Mail or Facsimile at 256-533-3213. ALL revocations must be sent to The Eye Center to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

**UNDERSTANDING YOUR HEALTH RECORD**

Each time you visit The Eye Center a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnostics, treatment, and a plan for future care or treatment. This information, often referred to as your medical record serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which your or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to:

ensures its accuracy, better understand who, what, when, where, and why others may access your health information, and make informed decisions when authorizing disclosures to others.

**PLEASE BE ADVISED PHONE CALLS MADE TO AND FROM THE EYE CENTER MAY BE MONITORED FOR QUALITY ASSURANCE**