DATE: _____ The EyeCenter 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? _____

EMPLOYER INFORMATION

EMPLOYER'S NAME	BUSINESS PHONE
SPOUSE'S EMPLOYER	BUSINESS PHONE

IF PATIENT IS A CHILD, PLEASE COMPLETE

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	

IF A PARENT IS UNABLE TO ATTEND A CHILD'S APPOINTMENT WHO MAY ACCOMPANY THE PATIENT

NAME	PHONE #	SSN
NAME	PHONE #	SSN

INSURANCE INFORMATION

DO YOU HAVE **MEDICAID** INSURANCE? **Y** **N**

PRIMARY INSURANCE		**DO YOU HAVE A SECONDARY INSURANCE? Y N**	
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