Southwest Florida Eye Care **Patient Information** **MR#**_____

Name:_____ Date of Birth: _____

Mailing Address:_____ Apt # _____ Social Security #: _____

City, State, Zip:_____ Home Phone: _____

E-Mail Address:_____ Work Phone: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Other Cell Phone: _____

Preferred Method of Communication: □ Email □ Phone □ Postal Mail Fax #:_____

Employer's Name or School Name: _____

Northern Address:_____ Northern Phone: _____

City, State, Zip:_____ Months at this address: _____

Health Insurance Information (Primary) - See back of page for Vision Insurance

Health Insurance Name: _____

Patient's Relationship to Policyholder: □ Self □ Spouse □ Child □ Other, specify:_____

If not patient, Policyholder:_____ Birth Date:_____ Social Security#: _____

Health Insurance Information (Secondary)

Health Insurance Name: _____

Patient's Relationship to Policyholder: □ Self □ Spouse □ Child □ Other, specify:_____

If not patient, Policyholder:_____ Birth Date:_____ Social Security#: _____

Guarantor (Person financially responsible for above named patient)

Patient's Relationship to Guarantor: □ Self □ Spouse □ Child □ Other, specify:_____

If not patient, Name:_____ Date of Birth: _____

Mailing Address:_____ Social Security #: _____

City, State, Zip:_____ Home Phone: _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any materials or professional services rendered.

Signature of Guarantor:_____ Date: _____

*****Turn over for additional information.*****

Vision Insurance Information

Vision Insurance Name: _____

Patient's Relationship to Policyholder: □ Self □ Spouse □ Child □ Other, specify:_____

If not patient, Policyholder: _____ Birth Date: _____ Social Security#: _____

Who is your primary care physician? _____

How did you hear about us? □ Newspaper Ad □ Insurance □ Website □ Radio □ Other_____

□ Friend _____ May we use your name in a thank you note? Yes / No
(Name)

□ Referring Physician _____

Emergency Contact Name_____Relationship:_____

Home Phone: _____ Work Phone:_____Cell Phone_____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please **INITIAL** one of the following:

_____ I give my permission to the employees of Southwest Florida Eye Care to disclose my Protected Health Information to me and following family or friends:

Name:_____Relationship: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

_____I request that all my Protected Health Information be disclosed only to me and no other family or friends.

We will always leave a detailed message on your answering machine/voicemail or with anyone who answers when we are contacting you to remind you of an appointment at our office.

I understand that I may revoke or change this authorization at anytime by filling out another Consent to Disclose Medical Information form. I understand that the information used or disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by Federal and State privacy laws. I understand this authorization will not expire and I have a right to receive a copy.

_____ _____
Signature of Patient or Representative Date

_____
Print Patient Name

Patient Name:_____
MR#: _____

Patient Acknowledgment & Consent

I understand that in the course of my care and treatment by Southwest Florida Eye Care, medical reports will be created. I consent to Southwest Florida Eye Care sending any reports regarding my evaluation, treatment, and follow-up care to any other healthcare providers involved in any of my care and treatment including my family physician. I understand that in the course of my treatment, the physicians at Southwest Florida Eye Care may have to review medical reports and records from other healthcare providers and consent to Southwest Florida Eye Care requesting and receiving those records they deem necessary.

I understand that in order to facilitate insurance or other third-party reimbursement for my care and treatment, that Southwest Florida Eye Care or its agents may have to share information about me with my insurance company or third-party payment source or their agents or employees (including my employer, if this is a worker's compensation claim). I consent to Southwest Florida Eye Care sharing the information necessary to properly process claims for reimbursement.

I hereby assign my right to be reimbursed from any insurance policy or from any person or organization that is or may become liable to me for any of the costs or fees associated with my care and treatment to Southwest Florida Eye Care and authorize payment directly to Southwest Florida Eye Care.

I understand and agree that I am individually obligated to pay for the care and treatment provided to me, including outstanding balances not covered by any insurance policy or other third-party payment source such as Medicare. I understand and agree that if I do not pay any amounts due, that I will be liable for any costs and fees associated with collecting those amounts, including collection fees, attorney's fees and court costs, if any.

I acknowledge the receipt of the Notice of Privacy Practices for Southwest Florida Eye Care, LLC.

_____
Patient/Guarantor Signature

_____ _____
Print Patient/Guarantor Name Date

Patient Name:_____ **MR#:**_____

Financial Policy

This is an acknowledgement agreement between Southwest Florida Eye Care and the patient named on this form.

Payment Is Expected At The Time Services Are Rendered

We will collect your co-payment, coinsurance, and any previous balance due at the time of service. We accept cash, check, Visa, Mastercard, American Express, and Discover.

Returned Checks: There is a $25.00 fee for any checks returned by your bank.

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT, FOR ANY MATERIALS, OR PROFESSIONAL SERVICES RENDERED.

MEDICARE: We do participate in Medicare Part B. We will bill services for you. You are responsible for your annual Medicare deductible and the 20% patient responsibility. You are also responsible for any services denied as not medically necessary or non-covered such as refractions.

REFRACTIONS: Refraction is a test to determine how much of one's blurred vision is due to refractive error (nearsightedness, farsightedness, or astigmatism) as opposed to an eye disease. It can also determine a glasses prescription. Refraction is NOT covered by Medicare and most commercial insurance companies. If performed during your examination, you will be **required** to pay the fee at the time services are provided.

PARTICIPATING/IN-NETWORK PROVIDERS: It is the responsibility of the patient to verify the physicians at Southwest Florida Eye Care are in-network providers with his/her insurance company. Patients are financially responsible for any out-of-network fees.

AUTHORIZATIONS/REFERRALS: If prior authorization/referral is required by your insurance company and we do not receive it prior to your appointment, you will accept responsibility for payment in full for that date of service.

WORKERS COMPENSATION CASES: We require written approval/authorization by your employer and/or the workers compensation carrier prior to your initial visit. If your claim is denied, you accept responsibility for payment in full.

PERSONAL INJURY/MOTOR VEHICLE ACCIDENTS: We do not file to automobile insurance. You will be responsible for payment in full. We do not accept letters of protection from attorneys.

I understand that if my account is submitted to an attorney or collection agency, or if my past due account is reported to a credit reporting agency, I will be held liable for any attorney or collection fees. The fact that I received treatment/ services at Southwest Florida Eye Care may become a matter of public record.

I acknowledge and agree to all terms and conditions contained, the agreement will be effective on the date indicated below.

Patient/Guarantor Signature _____

Print Patient/Guarantor Name _____

Date_____