Welcome to *Victoria Eye Center*. We're so glad that you chose us for your family eye care needs.

Patient Information Today's Date: _____

Last Name: _____ First Name: _____

Home Phone: _____ Work or Cell: _____ Email: _____
(circle)

Street Address: _____ City: _____ Zip: _____

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security Number: _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Family Information

Spouse's Name: _____ Date of Birth: _____ Employer: _____

If Minor
Father's Name: _____ Date of Birth: _____ Employer: _____

Mother's Name: _____ Date of Birth: _____ Employer: _____

In case of an emergency, whom should we contact?

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Other Information

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Reason for today's visit: _____

Insurance Information

Primary Insured: _____ SSN: _____ Date of Birth: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Medicare and Non-Medicare Patients: By signing below, you agree that you are **FINANCIALLY RESPONSIBLE** for any balance due because of co-pay or coinsurance, deductible, non-covered services, referral/authorization not obtained prior to visit, doctor not on insurance plan, or incorrect insurance information.

_____ _____

Signature Date

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE:
I hereby authorize Victoria Eye Center and/or Victoria Surgery Center to release information acquired in the course of my examination or treatment as necessary to receive payment from my insurance company.

ASSIGNMENT OF INSURANCE/MEDIGAP BENEFITS:
I hereby assign to Victoria Eye Center and/or Victoria Surgery Center all medical/surgical benefits to which I am entitled relative to the services performed, but not to exceed my indebtedness. I understand I am financially responsible for all charges.

FINANCIAL/INSURANCE POLICY: Please Read Carefully
We are participating Medicare providers. As a participating provider, we agree to accept the amount allowed by Medicare for patients that have Medicare as their primary insurance. After the yearly $183.00 deductible is met, Medicare pays 80% of the allowed amount leaving you responsible for the remaining 20%. If you have another insurance that pays the 20%, please make sure that you give the front desk a copy of your card. We will file the 20% to that company for you.

Medicare and some Commercial/PPO insurances do not consider a routine eye exam or refraction to be medically necessary and do not cover these services. Refraction is necessary to prescribe glasses and contact lenses, but also assists in determining and assessing the ocular health of the eye or the need for surgical procedures. **You are expected to pay for these services as well as any balance due because of applicable deductibles, co-insurances, co-pays, other non-covered services, authorization not obtained prior to visit, doctor not on insurance plan, or incorrect insurance information.**

Signature: _____ Date: _____

AUTHORIZATION TO COMMUNICATE W/ FAMILY OR OTHER PARTIES

If you wish that any information be discussed with someone <u>OTHER</u> than yourself, you must list their names below. Without this release Victoria Eye Center / Victoria Surgery Center cannot and will not discuss any information with anyone but <u>YOU</u>.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Information allowed to be discussed:
Medical: ☐ All ☐ Other (If you mark other, please see
Billing: ☐ All ☐ Other front desk staff)
Appointment: ☐ All ☐ Other

The purpose of this authorization is:

☐ At the request of the patient / patient's representative

☐ Other (state reason)

This authorization is valid for _____ days / months / years. If no date is provided, this authorization is valid for one year.

You have the right to revoke or change this authorization at any time; such change will only apply to information not already released. Should you wish to revoke or change this authorization, you must submit in writing to Victoria Eye Center/Victoria Surgery Center. You understand that you do not have to sign this form in order to receive treatment from Victoria Eye Center/Victoria Surgery Center.

_____ _____
(Patient or Patient's Representative Signature) (Today's Date)

Representative's relationship to patient: _____