PATIENT INFORMATION

PRIMARYCARE DOCTOR: ______________________________ Phone # __________________ FAX # ________________

PATIENT NAME: ____ BIRTHDATE: ____________________

SOCIAL SECURITY # ____ MARITAL STATUS: ( ) S ( ) M ( ) W ( ) D

HOME TELEPHONE # ______________________ **CELLULAR #** __________________ **WORK #**____________________

MAY WE LEAVE MESSAGES ON PHONE NUMBERS PROVIDED ABOVE? ( ) YES ( ) NO

STREET ADDRESS: ____ **APT. #** _____________

CITY: ____ **STATE:** __________________ **ZIP:** _______________

PATIENT EMAIL ADDRESS: ____

DRIVER'S LICENSE: ____ DRIVER'S LICENSE STATE: __________

EMPLOYER/SCHOOL: ______________________________________ TITLE: __________________ PHONE # ______________

SPOUSE NAME: ____ BIRTHDATE: _________________

PRIMARY LANGUAGE SPOKEN: ________________ ETHNICITY: ( ) HISP ( ) NON HISP ( ) UNKNOWN RACE: ( ) ASIAN ( ) BLACK ( )WHITE ( ) OTHER

REFERRED BY: ____

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NAME OF PHARMACY: ______________________________ PHONE # ______________________________

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IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME: ______________________________________ FATHER'S NAME: ___________________________________

EMPLOYED BY: ____ EMPLOYED BY: _____________________________________

PHONE # ____ PHONE # ____

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PRIMARY INSURANCE INFORMATION:

INSURANCE CO. __________________________________

ADDRESS: ______________________________________

CITY/STATE/ZIP: _________________________________

PHONE # ______________________________________

I.D. # __________________________ GRP # ___________

INSURED NAME OR # ______________________________

IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO

INSURED SOCIAL SEC. # ____________________ DOB: _________

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

SECONDARY INSURANCE INRORMATION:

INSURANCE CO. __________________________________

ADDRESS: ______________________________________

CITY/STATE/ZIP: _________________________________

PHONE # ______________________________________

I.D. # __________________________ GRP # ___________

INSURED NAME OR # ______________________________

IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO

INSURED SOCIAL SEC. # ____________________ DOB: _________

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

PHYSICIAN'S RELEASE & ASSIGNMENT

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to Miami Lakes Eye Care Center for any services furnished to me by that physician or supplier. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on Item 9 of the HCFA-1500 claim form or elsewhere on other approved electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SIGNATURE (Patient's parent if minor): ______________________________________ **DATE:** ____________________

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION*

I, ____(Patient name), *authorize* Miami Lakes Eye Care Center, to *release* or *discuss* information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1) ____________________________________ Relationship: ___________________

2) ____________________________________ Relationship: ___________________

3) ____________________________________ Relationship: ___________________

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* PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL **NOT BE GIVEN** ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.
* YOU ARE **NOT REQUIRED** TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

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Please list any *additional* phone numbers where you would like us to contact you or leave messages for:

* Reminder notices
* Changes on scheduled appointments

1. ____

2. ____

Patient Signature: ____

ACKNOWLEDGEMENT OF FEE

Form of payment for today's Services

Medical Insurance ___________________________________

Vision Insurance:___( ) VSP___( ) VCP___( ) Eyemed______.

Check One ( ) Cash ( ) Check ( ) Credit Card _______________________EXP _________

I understand there may be a separate Refraction Fee of $33.00 or Contact lens Fee for first time Fit of $70.00 and $35.00 / $45.00 for re-fit, for which my insurance may not cover.

Patient Name: ____________________________________ Date: _________________________

Signature: _______________________________________

I understand there is an added fee for returned checks and collections accounts.