Patient Demographic Form

Acct #:

Mountain View EYECENTER
www.mountainvieweyes.com

Patient Information

Last Name | **First Name** | **Middle Initial** | **Nickname / AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female ☐ Undiff. / Other:_____

Marital Status ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Separated ☐ Widowed ☐ Other:_____

Mailing Address | **Apt#** | **City** | **State** | **Zip Code**

Street Address (if different) | **Apt#** | **City** | **State** | **Zip Code**

Cell (or daytime) phone | **Home phone** | **Email**

Emergency Contact Information

Emergency Contact Name | **Relationship** | **Phone**

Guarantor Information

Relationship to Patient ☐ Self (skip to payment method) ☐ Parent / Guardian ☐ Spouse ☐ Other:_____

Last Name | **First Name** | **Cell (or daytime) phone**

Date of Birth | **Social Security Number**

Mailing Address | **Apt#** | **City** | **State** | **Zip Code**

Referral Information

How did you hear about us?

Signature of Patient or Legal Guardian

Date

Patient Insurance Form

Acct #: **Printed Name of Patient:**

www.mountainvieweyes.com

Vision vs. Medical Insurance:
Typically, vision coverage is for annual ocular screening exams, glasses, and contacts. Medical coverage includes medical examinations with an optometrist or an ophthalmologist and many tests, procedures, and imaging.

Medical Insurance

Primary Insurance Carrier (if none, please indicate SELFPAY)		**ID#**	**Policy Holder: SELF** ☐ *(If self: skip ahead to next carrier)*
Policy Holder's Full Legal Name	**Policy Holder's DOB**	**Policy Holder's SSN**	**Relationship to Patient**
Secondary Insurance Carrier		**ID#**	**Policy Holder: SELF** ☐ *(If self: skip ahead to next carrier)*
Policy Holder's Full Legal Name	**Policy Holder's DOB**	**Policy Holder's SSN**	**Relationship to Patient**
Tertiary Insurance Carrier		**ID#**	**Policy Holder: SELF** ☐ *(If self: skip ahead to next carrier)*
Policy Holder's Full Legal Name	**Policy Holder's DOB**	**Policy Holder's SSN**	**Relationship to Patient**

Vision Insurance

Primary Insurance Carrier (if none, please indicate SELFPAY)		**ID#**	**Policy Holder: SELF** ☐ *(If self: skip ahead to next carrier)*
Policy Holder's Full Legal Name	**Policy Holder's DOB**	**Policy Holder's SSN**	**Relationship to Patient**
Secondary Insurance Carrier		**ID#**	**Policy Holder: SELF** ☐ *(If self: skip ahead to next carrier)*
Policy Holder's Full Legal Name	**Policy Holder's DOB**	**Policy Holder's SSN**	**Relationship to Patient**
Tertiary Insurance Carrier		**ID#**	**Policy Holder: SELF** ☐ *(If self: skip ahead to next carrier)*
Policy Holder's Full Legal Name	**Policy Holder's DOB**	**Policy Holder's SSN**	**Relationship to Patient**

Signature of Patient or Legal Guardian **Date**

Acknowledgements

Acct #: **Printed Name of Patient:**

www.mountainvieweyes.com

Notice of Privacy Practices

Notice of Privacy Practices

I acknowledge that I have received a copy of Mountain View Eye Centers Notice of Privacy Practices. This notice describes how Mountain View Eye Center, Katherine Johnson, MD PC, may use and disclose my protected health information, restrictions on the use and disclosure of my healthcare information, and my rights regarding my health information.

Payment Policy

Payment Policy – You can access our Statement of Financial Polices and Billing processes at any time.

As a courtesy, Mountain View Eye Center (MVEC), verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. It is the policy of MVEC that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the conclusion of each visit.

If you are covered by health or vision insurance, we will be happy to bill your insurance. Please provide all insurance information prior to your visit and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contact your insurance carrier and check into your coverage for ophthalmology/optometry services. Do not assume that you will not owe anything if you have more than one insurance policy.

Assignment of Benefits

Assignment of Benefits

I acknowledge receipt and understanding of the payment policies and information listed here. I certify that the information on my Demographic and Insurance forms is true and accurate to the best of my knowledge. I acknowledge that I am responsible for all deductible, copay, co-insurance amounts, noncovered services, and items considered “not medically necessary” by my insurance.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any insurance carrier I may have, any information needed to determine these benefits, or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient or Legal Guardian **Date**

Authorization to Release Information Verbally

Patient Name:_____ DOB: _____

Account #:_____ SSN: _____

Information to be released/discussed:

- ☐ Medical Information
- ☐ Billing Information
- ☐ Diagnosis/ Treatment Plans
- ☐ Prescriptions/ Refills
- ☐ Appointment Information
- ☐ All Information/ Records
- ☐ Specific Date(s) of Service: _____
- ☐ All Dates of Service
- ☐ Can Make Changes
- ☐ Cannot Make Changes

To be released to whom:

Name:_____

Relation to Patient:_____

In accordance with HIPAA LAW, I, the above-listed patient, hereby authorize the staff and physicians at Katherine E Johnson MD PC, aka Mountain View Eye Center and Mountain View Optical Shoppe, to release the information in the form of verbal discussion with the individual named for the specified dates of service or until this authorization expires or is revoked. I understand that in order for the above-named individual to acquire any written documents regarding my health or my account, I will need to fill out a separate release of information form for specified dates of service. I acknowledge by my signature that I understand that although I am not required to release my information, I am giving my consent to do so. This authorization expires in three years or on_____, whichever is sooner. I understand that I may revoke this authorization in writing at any time before it expires, except for that information which has already been released with consent and prior to my revocation.

_____ _____

Signature of Patient or Legal Guardian **Date**