Mountain View EyeCenter

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PATIENT INFORMATION

Last: _____ First: _____ Middle: _____

Social Security #: _____ Date of Birth: _____ Sex: ❑ Male ❑ Female

Mailing Address: _____

Street Address (if different): _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ ☐ Home ☐ Cell ☐ Work ☐ Caregiver

Other Phone Number: _____ ☐ Home ☐ Cell ☐ Work ☐ Caregiver

Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Race (optional): ☐ American Indian ☐ Asian ☐ Black ☐ Pacific Islander ☐ White ☐ Other

Ethnicity (optional): ☐ Hispanic ☐ Not Hispanic

Do you speak English? ☐ Yes ☐ No *If no, what language do you speak? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Person Responsible for payment (if different from patient): _____

Date of Birth: _____ Social Security #: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Do you have an <u>active</u> Healthcare Power of Attorney? ❑ Yes* ❑ No

** If yes, please bring a copy so we can have it on record*

Primary Care Physician: _____ Phone: _____

Referring Physician(s): _____ Phone: _____

How did you hear about us? _____

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AUTHORIZATION TO RELEASE INFORMATION VERBALLY

Patient Name: _____ Date of Birth: _____

Social Security #: _____

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

Individual who is released for above permissions (personal representative):

Name: _____ Relation to Patient: _____

In accordance with HIPAA Law, I, the above-listed patient, hereby authorize the staff and physicians at Mountain View Eye Center to release 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

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CONSENT FOR DISCLOSURES

I understand that my healthcare information at Mountain View Eye Center is protected and I have received a copy of their Patient Notice of Privacy Practices.

In order for Mountain View Eye Clinic to leave detailed messages on my voicemail or answering machine, I need to give permission to Mountain View Eye Clinic to do so.

Consent for Leaving Messages

☐ I consent to information regarding my or my child's (under the age of 18) test results to detailed appointment reminders/instructions be left on my voicemail or answering machine. I understand that "sensitive" information as noted below will be excluded.

Consent to Observe

☐ I consent to allow trained medical personnel to briefly observe my exam.

Consent for Use of Photographic Materials

☐ I hereby give consent to use photographs of my eyes and face for educational purposes or scientific publication.

Consent for Shared Information with Family and Friends

☐ I wish family members or friends to have access to my healthcare information. Name(s) listed below are family members or friends to whom I grant access to my healthcare information through limited verbal disclosures.

I understand that some information is considered "sensitive." I understand that I must check the specified boxes in order for my provider, or his/her designee, to release any "sensitive" information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
- ☐ Pregnancy Information
- ☐ Sexually Transmitted Diseases
- ☐ HIV / AIDS Virus

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____

Patient Name (Print) _____ Date of Birth _____

Signature _____ Date Signed _____

This consent will be considered valid until such time as I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

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FINANCIAL POLICY

USUAL AND CUSTOMARY RATES: Mountain View Eye Center is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PAYMENT FOR SERVICES RENDERED: Mountain View Eye Center will require payment towards co-pays during the check-out process after that day's appointment. You are also encouraged to pay towards any past due balances on your account at this time as well. We accept most major credit cards, cash, check and Care Credit. There is a standard fee of $30 for every returned check.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you as long as you provide us with the correct information. You, as the patient, are ultimately responsible for payment of all services provided by Mountain View Eye Center. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. *Please be aware that some, and perhaps all, of the services provided may be a non-covered service and/or not considered medically necessary under your insurance plan.* We routinely perform diagnostic tests, such as **refractions** or **topography**, which some insurance carriers, including Medicare, will not cover. We use refraction as a diagnostic tool rather than to prescribe glasses, and topography to determine appropriate cataract treatment options. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you is not a covered benefit, you will be responsible for the bill.

ASSIGNMENT OF BENEFITS

I request the payment of authorized Medicare or other insurance company benefits be made on behalf of me or my dependent(s) to Mountain View Eye Center for any services provided. Regulations pertaining to Medicare assignment of benefits apply. Mountain View Eye Center accepts Medicare Part B assignment. 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. I authorize Mountain View Eye Center to release medical or other information pertaining to me or my dependent(s) to insurance carriers for related Medicare or other insurance company claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for me or my dependent(s) treatment.

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 agree that I will not withhold or delay payments if Medicare or other insurance companies deny payment on any of my or my dependent(s) charges.

Patient Name (Print) _____ Date of Birth _____

Signature _____ Date Signed _____