Michael C. Dorius. O.D.

Reviewed HIPPA: Initials_________ Date_________

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Mr.___Mrs.___Ms.___Name:____Date:________________

Address:____

Mailing Address(if different):____

City:___________________________________State:______________________ Zip:_______________________

Birthdate:_____/_____/_____Social Security #:______-______-______Home Phone:(____)______-________

Cell/Other Phone:(____)______-________Marital Status:____________________State of Birth:________________

Employed by:____Work Phone:(____)______-______Ext._____

Race(Circle one): American-Indian or Alaskan Native Asian Black or African American Native Hawaiian or Pacific Islander White

Ethnicity: Hispanic or Latino? Yes__No__ Preferred Language:______________________________

Mother's Maiden Name:_______________________ Email :____

Reminder preference? Phone __Text__Email__Mail__ Who referred you to our office? __________________

Account Responsible

Name:___________________________________Relationship:________________Birthdate:__________________

Billing Address (if different):____

City:___________________________________State:______________________ Zip:_______________________

Insurance Information

Primary Insurance:______________________________Policy #____

Policy Holder:________________Birthdate:________/__________/________Relationship: __________________

Secondary Insurance: ____________________________Policy #____

Policy Holder:________________Birthdate:________/__________/________Relationship: __________________

Last 4 of SSN:________________

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize the release of medical information necessary for the payment of services and materials provided by Hurricane Valley Eye Care. I hereby authorize Hurricane Valley Eye Care to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Hurricane Valley Eye Care on my behalf for any services and materials furnished. I understand that I am financially responsible, including all deductibles, for charges of Hurricane Valley Eye Care that are not paid by my insurance and/or Medicare. All medical care is due and payable upon completion unless prior arrangements have been specified. I acknowledge and agree that interest at the rate of 1 1/2 percent per month (18 percent per annum) will be charged on all balances remaining unpaid after said date of completion. I/We agree to pay all attorneys fees, court costs, filing fees, and all collection costs, up to 40 percent of amount owing may be assessed by any collection agency retained to pursue the matter.

Signature:____Date:_____________

<u>For Our Medicare Patients:</u>

*Medicare will not pay for covered services until the yearly deductible is met. This takes effect each January.
*Medicare will not pay for refractive services. This is the part of the eye exam that determines your prescription.
*Medicare will not pay for any services if the doctor only makes a refractive diagnosis during the exam. Ex: Nearsightedness
*Medicare does not pay for glasses or contact lenses unless you have had cataract surgery.
*Medicare does not cover deluxe frame charges in excess of the approved amount and does not cover extra lens options.
*Medicare will only pay for services that it determines to be "reasonable and necessary".

I have read and understand the information above and agree to pay for any services and materials not covered by Medicare.

Signature:____Date:_____________