CALIFORNIA EYE CLINIC
PATIENT INFORMATION FORM

INFORMATION ON PATIENT: Date:_____

Last name:_____First Name:_____Middle_____

DOB:_____Age:_____Home address:_____

City:_____State:_____Zip:_____Social Security #_____

Best contact phone number:_____Work phone:_____

Employer:_____Occupation: _____

Employers address:_____City:_____State:_____ Zip:_____

Emergency contact not living with you:_____Contact Phone:_____

Male_____ Female_____ Married_____ Single_____ Divorced_____ Separated_____ Widow/er_____

Name of Referring Doctor:_____Address:_____

INFORMATION ON SPOUSE:

Last name:_____FirstName:_____Middle_____

DOB:_____Social Security#_____Spouse's Employer:_____

Address:_____City:_____State:_____Zip:_____

MEDICAL INSURANCE INFORMATION:

Primary Insurance:_____Policyholder"s Name:_____

ID #_____Policyholder DOB:_____Amount of Copay_____

Secondary Insurance:_____Policyholder's Name:_____

ID #_____Policyholder DOB:_____Amount of Copay_____

Name of Vision Insurance Carrier:_____Policyholder's Name:_____

ID #_____Group #_____Policyholder DOB:_____

TO BE COMPLETED BY RESPONSIBLE PARTY (PARENT, GUARDIAN OR OTHER)

Last name:_____First Name:_____Middle_____

DOB:_____Age:_____Home address:_____

City:_____State:_____Zip:_____Social Security #_____

Best contact phone number:_____Work phone:_____

Employer:_____Occupation: _____

Employers address:_____City:_____State:_____ Zip:_____

Patient Name:_____

Did you sustain an injury at work? Y N

Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N

Have you ever served in the military: Y N

Are you covered under any other health care plan? Y N _____

Have you made any changes to your choice of Medicare options in the last open enrollment period? Y N

Who is responsible for this bill?_____

If I have received services by another provider for the condition for which I seek treatment today I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information given and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

I understand that services rendered to me by all the providers of the California Eye Clinic are my financial responsibility and that the provider will bill my first and second insurance carrier as a courtesy. I understand that any copay is to be made at the time services are rendered as per my agreement with my insurance company. I authorize my insurance company to pay my benefits directly to the California Eye Clinic and I understand that I will be fully responsible for any outstanding balance on my account. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I hereby authorize the providers of the California Eye Clinic to release any and all medical or billing information to my insurance carrier (or attorney) for purposes of claims administration , utilization review and financial audit or any reason as designated by the notice of privacy practices. In the case of a work related injury, I hereby authorize the release of any medical information to my workers compensation carrier as related to the specific injury.

I also understand that should my insurance company send payment to me, I will forward the payment to the California Eye Clinic within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read the authorization and understand it.

_____ _____

PATIENT'S SIGNATURE INSURED OR GUARDIAN'S SIGNATURE

SIGNATURE REQUIRED