Patient Information Sheet

Today's Date:		**Soc. Sec. #:**	
Last name:	**First:**		**Middle:**
Birthdate: / /	**Age:**	**Sex: Male** ☐ **Female** ☐	
Mailing Address:			
City:	**State:**		**Zip:**
Email Address:		**Cell Phone #: ( )**	
Home Phone #: ( )	**Work Phone #: ( )**		

Communication Preference: ☐ Email ☐ Phone ☐ Postal ☐ Text

Preferred Language: ☐ English ☐ Spanish

Race: ☐ American Indian/Alaska Asian ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Black/African American ☐ Hispanic ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ Not Hispanic or Latino

Marital Status:: ☐ Single ☐ Married ☐ Widowed ☐ Separated/Divorced

Occupation: ☐ Employed ☐ Homemaker ☐ Child/Student ☐ Retired ☐ Disabled

Employer:	**Position:**		
Business Address:	**City:**	**State:**	**Zip:**

Name of Person Responsible for Account:			
Relationship to Patient:	**Phone #:**		
Mailing Address:	**City:**	**State:**	**Zip:**
Employer:	**Work #:**		

I Give permission to the staff of Spectrum Eye Center to disclose personal Health information (including written, verbal or copied) regarding my eye exam visits to the following people :

Name:	**Phone #:**	**Relationship to PT:**	**Emergency Contact:** ☐
Name:	**Phone #:**	**Relationship to PT:**	**Emergency Contact:** ☐

I understand that I have the right to revoke or change this authorization by written request at any time I desire.

Insurance Information

Medical Primary Insurance	Medical Secondary Insurance	Vision Insurance

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I have received a copy of Spectrum Eye Center's Notice of Privacy Practices. I have read and understand it.

Please Print Patient Name	Patient or Parent/Guardian Signature

Privacy Policy: We, the Staff and Management of Spectrum Eye Center, are vigilant to protect patient confidentiality. No information regarding our patients is shared or distributed with any other person or organization without the patients' signed authorization. Any questions or comments may be directed to our Privacy Compliance Officer.

Your official signature is required on the reverse side of this form. All patients under the age of 18 are considered minors and must have a parent or legal quardian to sign and be present during the office visit. Thank you for choosing Spectrum Eye Center.

Signature on File, Assignment of Benefits, Financial Agreement

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Spectrum Eye Center, for services furnished me by Spectrum Eye Center. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for 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 is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Spectrum Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Spectrum Eye Center if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Spectrum Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Spectrum Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Spectrum Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Spectrum Eye Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Spectrum Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Spectrum Eye Center if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Spectrum Eye Center's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Spectrum Eye Center to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Spectrum Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Spectrum Eye Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Spectrum Eye Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Spectrum Eye Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

7. **CANCELLATION/NO SHOW POLICY:** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you may be charged a thirty-five dollar ($35) fee; this will not be covered by your insurance company.

8. **LATE FOR SCHEDULED APPOINTMENTS:** We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 10 minutes past their scheduled time we may have to reschedule the appointment.

9. **ACCOUNT BALANCES:** We will require that patients with balances, to pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a patient account representative with whom they can review their account and concerns.

Patient's Printed Name	Patient's/Guardian Signature	Date