OCEAN EYE INSTITUTE
PATIENT INFORMATION

Name_____ Date of Birth _____
Last First M .I.
Patient address_____City_____Zip_____

How Long _____ Patient Phone #_____ Cell Phone #_____

Marital Status S _____ M _____ D _____ W _____ Sex _____ Social Security # _____

Driver's license # _____ State issued _____
(If minor, please list driver's license # of responsible party)

If patient is minor, name of parent or guardian _____
Address of responsible party if different from patient_____
City_____Zip_____Phone #_____ Business # _____

I hereby authorize the physicians of the Ocean Eye Institute to treat my minor child
_____ (Parent/guardian signature)

Name and # of person to contact in case of emergency _____Phone #_____

Employment Status:
Employed: YES NO Patient's employer _____
Disabled: YES NO Address_____
Retired: YES NO Phone
Number_____
Student: FT PT *(If minor, please list employer of responsible party)*

INSURANCE INFORMATION

Primary Insurance Co. _____ID# _____
Subscriber Name_____Birth Date _____Group#_____
Subscriber Address_____Phone #_____Employer_____
Retired: YES NO

Secondary Insurance Co. _____ID#_____
Subscriber Name_____Birth Date _____Group#_____
Subscriber Address_____Phone #_____Employer_____
Retired: YES NO

Tertiary Insurance Co. _____ID#_____
Subscriber Name_____Birth Date _____Group#_____
Subscriber Address_____Phone #_____Employer_____
Retired: YES NO

Routine Vision Coverage: (CIRCLE ONE) **Separate Vision Plan** **Routine Exam thru Medical Coverage**
Vision Plan: _____ ID# _____
Subscriber Name_____Birth Date _____Group#_____
Subscriber Address_____Phone #_____Employer_____

Medical History
Present eye complaint _____
Do you wear contact lenses? YES NO Are you interested in wearing contacts? YES NO
Family physician_____
FIRST LAST ADDRESS PHONE#
Referred by _____

Patient Agreement and Consent to Treatment

In order for Ocean Eye Institute to provide our patients with the best quality of medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for services rendered is our patients' responsibility. Please carefully read this document which explains the obligations we require from our patients and how our patients meet these obligations. In exchange for services rendered, each patient agrees:

1. To authorize payment of medical and surgical benefits to Ocean Eye Institute for services rendered to me. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment is correct.
2. To pay for all non-covered charges, copays, co-insurance, deductibles, out-of-network charges and refractions (the measurement of the eye in order to obtain a prescription for contacts or glasses) at the time of service or when otherwise advised. If this is not possible, you agree to contact our Billing Department to make payment arrangements.
3. To provide us with a copy of your most recent insurance card or other proof of insurance at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit and your insurance company subsequently denies our claim, you will be held personally responsible for any and all charges.
4. To obtain any referrals and authorizations required by your insurance plan/Primary Care Physician prior to each appointment. If you do not receive the required authorization and your insurance company denies your services, you are personally responsible for any and all charges. You are responsible to know and understand your insurance plan.
5. To monitor your insurance company for payments for your account. If claims remain unpaid you may be asked to contact them regarding non-payment. You agree to cooperate with Ocean Eye Institute to resolve the unpaid status of your account.

As a courtesy to our self-pay patients seeking routine eye care, Ocean Eye Institute will provide a reduced charge for payment at the time of service. The entire balance must be paid in full to receive the discount. Once you accept the discount, Ocean Eye Institute will not be responsible for filing claims to any insurance company. It is your responsibility to inform us at the point of service if you have insurance coverage for "routine" eye services.

The undersigned, whether as the patient or the guarantor for a patient, agrees that in consideration of the services rendered by Ocean Eye Institute, that you are individually obligated to pay for such services in accordance with the regular rates, terms and conditions of Ocean Eye Institute. In the event we must refer a patient's account to an attorney or collection agency for collection of an amount 90 days or older, the undersigned agrees to pay all attorney fees, collection expenses, and any bank fees incurred from a returned check.

I voluntarily consent to healthcare treatment from the physicians and staff at Ocean Eye Institute. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and operations.

I have read this form, and my signature represents that I understand and agree to be bound by the above provisions.

Name (Patient or Guarantor) _____ Date _____

Signature _____

Revised 09/12