

PERSONAL INFORMATION

NAME _____ I GO BY: _____ DATE _____
Last First MI Title
DATE OF BIRTH ____ / ____ / ____ AGE ____ SSN ____ - ____ - ____ EMAIL _____
HOME ADDRESS _____ HOME PHONE _____
Street City State Zip
OCCUPATION _____ EMPLOYER/SCHOOL _____ WORK PHONE _____
EMERGENCY CONTACT _____ Phone # of Emergency Contact _____
GUARDIAN (If under 18) _____ Guardian's Relationship to Patient _____
GUARDIAN'S ADDRESS (If different) _____
HOW DID YOU HEAR ABOUT US? Yellow Pages ____ Location ____ Recommendation ____ Insurance List ____ Other ____
WHOM SHOULD WE THANK FOR THE REFERRAL? _____ Marital Status (circle one): Single Married Other

INSURANCE INFORMATION

NAME OF PRIMARY MEDICAL INSURANCE _____ PRIMARY MEMBER _____
THEIR DOB ____ / ____ / ____ MEMBER ID# _____ GROUP# _____
THEIR RELATIONSHIP TO PATIENT _____ VISION INSURANCE _____
MEMBER ID# _____ GROUP# _____

I hereby authorize payment of health and/or vision insurance benefits to Bailey Cove Eye Care, P.C. for professional services rendered. I authorize the release of any medical records or information required from them for the determination or payment of benefits. I understand that Bailey Cove Eye Care, P.C. accepts assignment for Medicare, Blue Cross, and certain other plans with which it is affiliated, and that I am responsible for any deductibles, co-pays, and/or fees for non-covered services such as deluxe frames or contact lens fittings, etc.

RESPONSIBLE PARTIES SIGNATURE DATE _____

FINANCIAL POLICY

If you have insurance which we do not carry, or we know from experience will not pay benefits directly to us, you will be responsible for any services rendered, and we will gladly file your insurance to reimburse you. We will assist you as much as possible, however it is your responsibility to handle any problems that arise with your insurance company and it is your responsibility to know your insurance coverage. You are also responsible for obtaining referrals if required. If a balance remains on your account after 90 days, a 1.5% late fee will be added monthly to the unpaid balance. There is a \$25.00 returned check fee. A 50% deposit is required on all orders at the time of the order and the balance is due in full at time of dispensing. We will charge \$20 for failing to cancel any appointments within 24 hours.

I HAVE READ AND UNDERSTOOD THE ABOVE STATED POLICY AND AGREE TO ALL ITS CONDITIONS. I ALSO AGREE THAT IF IN THE UNUSUAL EVENT MY ACCOUNT BECOMES DELINQUENT, I WILL PAY ANY COLLECTION FEES REQUIRED TO SETTLE MY ACCOUNT.

RESPONSIBLE PARTIES SIGNATURE DATE _____

PRIVACY

I have read the "CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS" form and understand it. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

PATIENT _____ DATE _____

I ACKNOWLEDGE THAT I CAN RECEIVE A COPY OF BAILEY COVE EYE CARE, P.C. WRITTEN "NOTICE OF PRIVACY PRACTICES" (NPP) AT NO CHARGE

PATIENT NAME _____ SIGNATURE _____ DATE _____
(NPP Effective Date 4 - 1 - 2003)

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form: RELATIONSHIP TO PATIENT _____ PRINT NAME _____

We take routine retinal photographs of all new patients to help with disease detection and management, as well as to help establish baseline retinal and optic nerve health and appearance. These pictures are not covered by all insurance plans but we feel that they help significantly in the care of our patients.