PERSONAL INFORMATION

NAME _____ I GO BY: _____ DATE_____
Last First MI Title

DATE OF BIRTH____/____/_____ AGE____ SSN _____ - _____ - _____ EMAIL_____

HOME ADDRESS_____MAIN PHONE _____
Street City State Zip

OCCUPATION _____ EMPLOYER/SCHOOL_____ OTHER 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.

_____ DATE _____
RESPONSIBLE PARTIES SIGNATURE

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. 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.

_____ DATE _____
RESPONSIBLE PARTIES SIGNATURE

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 9-1-2013)

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 _____

OTHER PEOPLE AUTHORIZED TO GET MY INFORMATION: 1 _____ 2_____

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.