Alabama Eye Physicians and Surgeons
5937 West Main Street
Dothan, AL. 36305

PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth _____

Address _____

City, State, Zip Code _____

Social Security Number _____ Gender: Male/Female Race: _____

Marital Status _____ Home Phone_____

Cell Phone _____ Work Phone _____

Employer: _____

Employer Address: _____

Email Address _____

INSURANCE COMPANY

Primary Insurance _____ Secondary Ins_____

Tertiary Insurance _____ Insureds Date of Birth _____
(If different from patient)

RESPONSIBLE PARTY IF UNDER AGE 19

Name _____ Date of Birth _____

Address _____

Relationship to Patient: _____ Phone Number _____

EMERGENCY CONTACT

Name _____ Date of Birth _____

Address _____

Relationship to Patient: _____ Phone Number _____

Optometrist: _____

Primary Care Physician: _____

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Dothan, Alabama 36305
(334)446-0872

ASSIGNMENT OF INSURANCE BENEFITS FORM

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE ON MY BEHALF TO ALABAMA EYE PHYSICIANS AND SURGEONS FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER/CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier* as *the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.*

Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Print Name _____

Signature _____Date _____

ALABAMA EYE
PHYSICIANS & SURGEONS

5937 W Main St, Dothan, Al 36305
Tel. 334-446-0872, Fax 334-446-0893
www.Alabama-Eye.com

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as oppposed to **routine eye exams**. We do not participate with **ANY** vision plans (VSP, Davis Vision, etc.). **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referrral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

It is the patient's/parent's/guardian's responsibility to:

1. Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
2. Bring all of your current insurance cards to all visits.
3. Provide our office with current information including address, phone numbers ad employer.
4. In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. We accept cash, checks and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a $35.00 returned check fee.

There is a charge for completing various forms, including your DMV form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number, We request that you inform the subscriber that their insurance has been used.

I have read and understand the above financial policy.

_____ _____

Signature of patient/guardian/parent Date

_____

Printed name of patient

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AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?
□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize _____ to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.
I have reviewed the Alabama Eye Physicians and Surgeons Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

WITNESSED BY: _____