

OREGON EYE ASSOCIATES, LLP & AFFILIATES

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Oregon Eye Surgery Center Special Procedures Focal Point Optical

It is important that you complete all the following:

Patient Name: _____ DOB: _____ F ___ M ___ SSN: _____ (PATIENT SSN ONLY)

Race: [] American Indian or Alaska Native [] Asian [] Black or African American [] White
[] Native Hawaiian or Pacific Islander [] Unknown [] Other [] Decline to answer

Ethnicity: [] Hispanic or Latino ethnicity [] Non-Hispanic or Latino ethnicity [] Unknown [] Decline to answer

Preferred Language: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____ Occupation: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____ Spouse's Name _____

Primary Care Physician: _____ Spouse's Employer: _____

PCP Location (city/state) _____ Spouse's SSN: _____

Emergency Contact: _____
(Different from Home Address/Phone) (Name) (Phone) (Relationship)

RESPONSIBLE PARTY:

Name: _____ DOB: _____ SSN: _____ Home Phone: _____

Address: _____ City: _____ STATE: _____ ZIP: _____

Employer: _____ Work Phone: _____

How did you hear about us? ___ YELLOW PAGES ___ TV ___ RADIO ___ INSURANCE LIST ___ FRIEND ___ RELATIVE
___ PREVIOUS PT. ___ NEWSPAPER ___ DR. ___ OTHER

(Please present your insurance cards for photocopying)

MEDICAL INSURANCE:

Primary: _____ Subscriber: _____ DOB: _____ ID #: _____
Secondary: _____ Subscriber: _____ DOB: _____ ID #: _____
Tertiary: _____ Subscriber: _____ DOB: _____ ID #: _____

VISION INSURANCE:

Primary/Secondary: _____ / _____ Subscriber: _____ / _____ DOB: _____ / _____ ID #: _____ / _____

OR are we billing: ___ Worker's Comp Date Occurred: _____ Ins.Co. _____ Claim #: _____
___ Auto Insurance Date Occurred: _____ Ins.Co. _____ Claim #: _____

All professional services rendered are charged to the patient or responsible party. We will file claims with the patient's insurance carrier; however, the patient is responsible for all fees, co-payments, and/or insurance deductibles, as well as any amount not covered by insurance. Payment of co-payments and insurance deductibles is expected when services are rendered unless other arrangements have been made with our business office in advance.

I request that payment of authorized Medicare benefits be made either to me or to the provider named above for any services furnished me. I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine these benefits or benefits 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. The Provider 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.

I further give my permission for the release of information regarding my diagnosis, test results and/or prescriptions to anyone answering at my home telephone number or for the leaving of that information on my home answering machine and I permit the use of my e-mail address to contact me.

I hereby assign to the physician, if assignment is taken, all payments for medical services rendered.

I have been offered the HIPAA Privacy Practices.

I give my permission for affiliates of Oregon Eye Associates to speak to _____ / _____ regarding my healthcare.
(Name) (Relationship)

Date: _____ Signature: _____

Patient Signature (Parent or Guardian if patient is a minor)