TOOMEY & BAGGETT EYECARE CLINIC
PATIENT INFORMATION

PATIENT DEMOGRAPHICS

PATIENT NAME: _____BIRTHDATE:_____

HOME ADDRESS: _____MARITAL STATUS: _____

CITY: _____STATE_____ZIP_____SEX: M_____F_____

HOME PHONE:_____CELL PHONE:_____

SOCIAL SECURITY #:_____E-MAIL: _____

EMPLOYER:_____EMPLOYER PHONE:_____

SPOUSE/PARENT OR LEGAL GUARDIAN NAME, IF MINOR: _____

BIRTHDATE: _____EMPLOYER:_____

IF STUDENT, GRADE LEVEL:_____SCHOOL:_____

EMERGENCY CONTACT NAME: _____PHONE:_____

(THIS IS SOMEONE THAT DOES NOT LIVE AT PATIENT'S ADDRESS OR PHONE)

FINANCIAL POLICY

As a courtesy to our patients, we file most medical insurance claims. I understand that I am financially responsible for all charges incurred in the event that my insurance denied payment. I also understand that eye refractions and routine eye examinations are not covered by Medicare and other insurers and that I am responsible for payment of this service. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICES RENDERED.

PATIENT SIGNATURE: _____DATE:_____

PARENT/GUARDIAN SIGNATURE (if minor):_____DATE:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

□INTERNET □PHONE BOOK □OTHER_____ □PERSON _____

(Name of person)

PATIENTS READ AND SIGN AGREEMENT:

1. I hereby give my consent for Toomey & Baggett Eyecare to evaluate and treat the above patient.
2. I have been provided with the Privacy Practices Notice.
3. I understand that my personal health information will be used for the purpose of treatment, payment and the coordination of health care needs of the patient.
4. I have also been provided with the Financial Policy.

_____ _____ _____

Patient Signature (or Responsible Party if minor) Relationship Date

Patient Name _____ **DOB** _____/_____/_____

Payment for services is expected and due at the time of your visit.

Please acknowledge acceptance of this policy by your initials and signing and dating the form below:

Initials _____

Life Time Authorization for Insurance Payments

We request your signature on file, in the event the office files insurance for you or for any office procedure. This clause applies to **all insurance carriers.**

I request that payment of authorized carrier of Medicare benefits be made either to me or on my behalf to Toomey & Baggett Eyecare Clinic, PLLC for any services furnished me by this/these doctors. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Initials _____

Notice of Privacy Practices Patient Acknowledgement

I have had the opportunity to receive this practice's Notice of Privacy Practices. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Initials _____

Medicare Does Not Cover the Refraction or Eyewear

As a convenience to our patients, we are a participating provider for Medicare. We will bill Medicare for your visits. Medicare then reviews all claims, and if approved, reimburses our office 80% of the allowed amount. The remaining 20% is your responsibility, called a co-payment. You may also be responsible for an annual deductible and any non-covered fees. Each January, Medicare starts with a new deductible that must be met before claims are paid. If we are the first to file a claim for you this year, it is likely you will not have met your deductible and will owe for the full allowed amount.

Medicare does not pay for refractive services. This is the vision evaluation part of the examination that determines your eyeglass prescription. Medicare will not pay for routine eye exam services.

If you have a lens implant as the result of cataract surgery, Medicare may cover conventional lenses and frames one time. Medicare does not cover deluxe frames that are more than the allowance. Standard frames that are completely covered are available. Medicare also does not cover lens treatments such as scratch and anti-reflective coatings. These charges will be your responsibility.

Signature _____ Date _____

Relationship to patient if guardian _____