UNIVERSITY EYE SPECIALISTS

COMPLETE BOTH SIDES!

PATIENT INFORMATION

Patient Last Name _____ First _____ Middle _____

Address _____ Sex: M F Birthdate _____ Age _____

City, State _____ Marital Status: ☐S ☐M ☐D ☐W ☐Legally Separated

Zip _____ Home Phone (_____)_____ Race:_____

Cell Phone (_____)_____ Ethnicity_____

Email Address _____ Preferred Language:_____

Preferred Contact _____ Student: Full time ☐ Part time ☐

Social Security No._____ Family Physician _____
(FIRST NAME LAST NAME)

Employer Name _____ Emergency Contact:
(NAME / RELATIONSHIP)
_____ / _____

Employer Address _____ Phone (_____)_____

Employer Phone (_____)_____ Referring Physician _____
(FIRST NAME LAST NAME)

GUARANTOR INFORMATION (Person responsible for payment of personal balance) Same as above ☐

Guarantor Last Name _____ First _____ Middle _____

Address _____ Employer Name _____

City, State _____ Employer Address _____

Zip _____ Phone _____)_____ Employer Phone (_____)_____

Birthdate _____ Relationship to patient_____ Social Security No. _____

INSURANCE INFORMATION

PRIMARY

Insurance Company Name _____

Name of Policy Holder _____ Relationship to patient _____

Policy Holders Date of Birth _____/ _____/ _____ Social Security # _____

Policy Number _____ Group Number _____ Effective Dates _____

SECONDARY

Insurance Company Name _____

Name of Policy Holder _____ Relationship to patient _____

Policy Holders Date of Birth _____/ _____/ _____ Social Security # _____

Policy Number _____ Group Number _____ Effective Dates _____

VISION INSURANCE

☐ Eyemed Vision ☐ Davis Vision ☐ Superior Vision

Name of Policy Holder _____ Relationship to patient _____

Policy Holders Date of Birth _____/ _____/ _____ Social Security # _____

Policy Number _____ Group Number _____ Effective Dates _____

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

Patient Name: _____ **Date of Birth** _____

FINANCIAL ASSIGNMENT AND AGREEMENTS

- I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to University Eye Specialists, PC (UES) for any services furnished me by them. I authorize any holder of Medical information about me to release to the Center for Medicare/Medicaid Services, its agents, and/or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

- **I understand that I am financially responsible for all charges incurred.** For example, any co-pays, non-covered/denied services, and any charges not paid by my insurance company because referrals/ authorizations were not obtained prior to services, or incorrect insurance information was given or because UES does not participate with my insurance plan.

- Medical insurances (example: Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.

- I acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, making driving difficult. (Please ask for assistance if your vision is markedly affected.)

- I understand that if a check is returned to UES for any reason, there will be an additional $15.00 charge.

- I understand that if contact lenses are prescribed there may be extra charges for the fitting of those contact lenses or for the evaluation of the contact lenses which I am wearing currently. I understand that a prescription for contacts may be released provided lenses were dispensed by UES and examined by a practitioner of UES. I understand that UES will be unable to release prescriptions on contact lenses not dispensed by their office and/or not previously examined by a UES physician.

- I authorize University Eye Specialists, PC to communicate with me by phone, answering machine, text, email, or letter at home or business regarding appointments, care, or billing.

- I agree to the release of my medical information to my personal physician(s), ophthalmologist(s) or optometrist(s).

- **I give permission to discuss my medical information with the specific individuals named below: (examples: spouse, adult children, caregiver, emergency contact)**

1. _____ (Name) _____ (Relationship)
2. _____ (Name) _____ (Relationship)
3. _____ (Name) _____ (Relationship)
4. _____ (Name) _____ (Relationship)

I acknowledge that a copy of **University Eye Specialists, PC's Notice of Privacy Practices** has been provided to me for review and that a copy is available at my request.

Signature: _____ Date: _____
(Patient or legal guardian)

Witness: _____ Date: _____
(Practice Representative)