BAILEY EYE Care

First _____Last _____ MI ___ Date of Birth _____SSN_____-___-_____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Email _____ Occupation _____ Name of Employer _____

Responsible Party (Person who carries the insurance) Name _____

Relationship to patient _____ Date of Birth _____SSN_____-_____-_____

Address (if different than patient)_____City _____ State _____ Zip _____

Who referred you to our office? _____

Please list any members of your household who come to our office _____
_____

Special visual demands (work or hobbies) _____

Please check the box if **you** have ever had: ❑ Cataract ❑ Glaucoma ❑Lazy Eye ❑Macular Degeneration
❑Eye Injury/Surgery ❑ Allergies ❑ High Blood Pressure Do you smoke?❑Yes ❑No

Any bloodline relatives have glaucoma or vision loss? _____

Are you diabetic/ pre-diabetic ❑Yes ❑No If yes, what year were you diagnosed? _____

List any medical problems _____

Family doctor _____ Previous Eye Doctor _____

Do you presently wear glasses? ❑Yes ❑No How old are the glasses? _____

When do you wear them? _____

Do you presently wear contact lenses? ❑Yes ❑No ❑ Monthly ❑ Daily ❑ Gas Perm ❑ Other

How old are your contacts? _____ If no, have you ever worn contacts? ❑Yes ❑ No

About Your Insurance

There are two types of insurance that will help you pay for your eye care, services and products. You may have both types and we may be a provider for both.

- **VISION** plans cover only routine wellness exams, along with glasses and contacts. A routine exam means that there is not a medical diagnosis. A routine diagnosis is myopia (nearsighted) , hyperopia (farsighted), astigmatism, or presbyopia.
- **MEDICAL** insurance must be used for medical eye care (diabetes, cataracts, glaucoma, dry eye, conjunctivitis etc.)
- If you have both types of insurance it may be necessary to file a **coordination of benefits** to minimize your out-of-pocket expenses if your insurance allows it.
- If some fees are not paid by your insurance, you will be responsible for them (such as deductibles, co-pays, or non-covered services allowed by insurance contract).
- If we do not accept direct payment from your insurance, you will need to provide payment the day of service and submit a receipt for reimbursement from your insurance.

By signing below I acknowledge that the **Bailey Eye Care Financial Policy** is available to me and a copy will be provided upon request.

Medical information Release of Information

Due to HIPPA regulations, by signing below I authorize the following names listed below to discuss and participate in my medical care (names of family/friends who we may speak with on your behalf). This release will remain in effect until terminated by me in writing.

Name/ Relationship: _____

Name/ Relationship: _____

By signing below, this acknowledges the Receipt of Privacy Practices, I acknowledge and agree that I have received, read and understood the Notice of Privacy Practices for review on the date identified below. I understand that Bailey Eye Care may use and disclose the necessary personal health information to another party to permit Bailey Eye Care to perform administrative duties, provide eye care and services, process my insurance claims and communicate with me regarding eye care services.

Signature _____ Date _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to patient _____ Representative Name_____

MEDICARE PATIENTS ONLY:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Bailey Eye Care for any services provided to me by this provider. To the extent permitted by law, I authorize any holder of medical or other information about me to be released to the Centers for Medicare and any agents the information needed to determine these benefits for related services.

Signature of Beneficiary/ Representative _____ Date: _____

Printed Name of Beneficiary/Representative _____ Relationship_____