EASTERN MEDICAL EYE CENTER

PATIENT INFORMATION

Patient Name _____ Date of Birth: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Marital Status: Single Married Divorced Widowed Gender: Male Female

Social Security # _____ Race _____

EMAIL _____

Employer _____ Work Phone _____

PRIMARY CARE PHYSICIAN _____ Phone _____

PHARMACY _____ City _____ Phone _____

PRIMARY INSURANCE

COMPANY _____

CONTRACT# _____

GROUP# _____

INSURED'S NAME _____

INSURED DOB _____

SECONDARY INSURANCE

COMPANY _____

CONTRACT# _____

GROUP# _____

INSURED'S NAME _____

INSURED DOB _____

INSURANCE REFERRALS

I understand that if my insurance should require a referral to see the doctor today or at any time during my treatment, it is my responsibility to provide your office with the referral. If my insurance company denies payment – due to no referral – I agree to pay Eastern Medical Eye Center in full for any charges incurred during my visit.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

INSURANCE RELEASE INFORMATION

I hereby authorize the practice of Eastern Medical Eye Center to release any information concerning my medical condition, treatment, and prognosis to my insurance carriers and other treatment physicians.

I hereby authorize Eastern Medical Eye Center to furnish any information concerning my medical condition, treatment, and prognosis to my insurance carriers and other treatment physicians. I hereby assign Eastern Medical Eye Center all payments for medical and/or surgical services rendered to me or my dependents due or received from third-party providers. I agree to be responsible for any amount not covered by my insurance or other providers. I agree to pay all costs of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection), and interest on the unpaid balance at the rate of ten (10%) percent per annum. I hereby waiver all rights of exemption under the U.S. and Alabama Constitutions and the laws of the State of Alabama.

I hereby assign to Eastern Medical Eye Center - Insurance or other third-party benefits available for health care services provided to me. I understand that Eastern Medical Eye Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Eastern Medical Eye Center I agree to forward to Eastern Medical Eye Center all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

EASTERN MEDICAL EYE CENTER, P.C.
52 Medical Park East Drive
Suite 211
Birmingham, AL 35235
205/838-3696

John S. Morgan, M.D.

Jeff Chaiprakob, M.D.

PATIENT CONTACT FORM

Eastern Medical Eye Center is committed to the protection of the privacy of your Protected Health Information (PHI). Federal Regulations provide you certain rights with regard to how we disclose your information, and to whom your information may be disclosed. For a complete explanation of your rights and our obligations, please see our **NOTICE OF PRIVACY PRACTICES** available at the reception desk.

******PLEASE READ CAREFULLY AND CHECK ALL THAT APPLY******

YES	NO	
[ ]	[ ]	I authorize the physicians and staff of Eastern Medical Eye Center, P.C. to discuss details regarding my medical condition, treatment, lab results, prescription information, appointments, medical updates and all other Protected Health Information (PHI), without prior authorization, to the following family members or friends:

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

****IN ORDER TO COMPLY WITH FEDERAL REGULATIONS AND INSURE THE PRIVACY OF ALL PATIENTS, WE REQUEST THAT NOT MORE THAN ONE FRIEND OR RELATIVE ACCOMPANY YOU TO YOUR EXAMINATION****

YES	NO	
[ ]	[ ]	The physicians and staff of EMEC may confirm appointments via automated call system to my answering machine at the number provided on my Patient Information Form. (Please write N/A if you do not have an answering machine)
[ ]	[ ]	The physicians and staff may leave lab results on my answering machine. (Please write N/A if you do not have an answering machine)
[ ]	[ ]	The physicians and staff may release information to my pharmacy without prior authorization in order to call in prescriptions.
[ ]	[ ]	The physicians and staff of EMEC may use contact information contained in my record to mail information to me pertinent to general health related issues or practice promotional information at the address provided on my patient information form without prior authorization

SPECIAL INSTRUCTIONS:_____

My signature below is acknowledgement that I have received a copy of the **NOTICE OF PRIVACY PRACTICES** and that I agree to the conditions stated in the notice.

PATIENT SIGNATURE: _____ **DATE:** _____

This agreement will remain in effect until revoked in writing to the attention of our Privacy Officer unless an expiration date and patient signature is indicated below:

EXPIRATION DATE: _____ **PATIENT SIGNATURE:** _____

REFRACTION SERVICE AND FEE

A refraction is the process of determining your best corrective vision by performing tests using computerized technology or the physician/technician. It is an essential part of an eye examination and necessary in order to write a prescription for glasses and/or contact lenses, or prior to cataract surgery.

Most medical insurance plans, including Medicare, do NOT cover refractions. If your insurance plan has vision coverage and allows a yearly routine examination, please let us know at the time of your visit so we can file your claim accordingly.

Our office fee for refraction is **$35.00** and is collected at the time of service in addition to any co-payment your plan may require. Should we receive payment from your insurance company for the refraction, we will reimburse you accordingly.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance and/or deductible I may have are separate from the refraction fee.

_____ I request to have the refraction performed and understand I am responsible for the $35.00 refraction fee.

_____ I do **NOT** wish to have the refraction performed and understand that I will not receive a new prescription at my visit.

_____ _____

Patient Signature (Parent for Minor) Date