Westside Eye Clinic

PATIENT'S INFORMATION Today's Date: _____

First Name | MI | Last Name | Date of Birth

Social Security Number | Gender | Marital Status | Spouse

Home Address | City | State | Zip Code

Home Phone | Work Phone | Cell Phone | Preferred Contact

Email: _____

Race: _____ Ethnicity: _____

Employer | Occupation / Retired

Employer Address | City | State | Zip Code

Referred By: Yellow Pages / Internet / Friend / Doctor

Emergency Contact

Name | Relationship

Home Phone | Work or Cell Phone

IF PATIENT IS A MINOR PLEASE COMPLETE

Mother's Full Name | Social Security Number | Date of Birth

Mother's address if different from above

Father's Full Name | Social Security Number | Date of Birth

Father's address if different from above

PHARMACY INFORMATION

Preferred Pharmacy _____ Address _____

Pharmacy Phone Number _____

PHYSICIAN INFORMATION

Primary Care Physician _____ Phone Number _____

Referring Physician _____ Phone Number _____

INSURANCE INFORMATION

Primary Insurance _____	Policyholder's Name _____	Date of Birth _____	Social Security Number _____
Secondary Insurance _____	Policyholder's Name _____	Date of Birth _____	Social Security Number _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff of Westside Eye Clinic to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Westside Eye Clinic.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:	**Relationship:**

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to Westside Eye Clinic's use and disclosure of protected health information about myself for treatment, payment and health care operations.

I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I understand that payment for co-pays, co-insurance, deductibles and non-covered services are due at the time of service. I also acknowledge that non-payment of my account may result in collections proceedings.

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Westside Eye Clinic

_____ **Signature of the Patient or Patient Representative**

_____ **Date**

WESTSIDE EYE CLINIC

REFRACTION POLICY

1. **What is a refraction?**

Refraction is the procedure in which we determine the best corrected visual acuity of each eye for purposes of medical evaluation or for prescribing glasses, contact lenses, or corrective surgery.

2. **Why is it sometimes necessary?**

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription. As you can see a refraction is an essential part of an eye exam, however, Medicare and most insurance do not cover it.

3. **How much is it?**

If the refraction is a non covered service with your insurance, our office policy is to charge **$30.00** for this procedure in addition to the office visit copay and/or deductible. This is due at the time services are rendered.

Note: This fee is due and payable **whether or not** you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and new prescriptions will not be given.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in, the refraction fee.

_____ _____

Patient signature (Parent for minor) Date