OREGON EYE ASSOCIATES, LLP & AFFILIATES

I. Howard Fine, M.D.   Richard S. Hoffman, M.D.   Annete Chang Sims, M.D.

Oregon Eye Surgery Center & Focal Point Optical

Patient Name: ____ **DOB:** ___/___/___ **M** ☐ **F** ☐ **SSN:** _____-_____-____

Preferred Contact Method: Cell Phone ☐ Text Message ☐ Home Phone ☐ Email ☐

Race: **American Indian** ☐ **Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **White** ☐ **Native Hawaiian or Pacific Islander** ☐

Decline ☐ ***Preferred Language:*** ______________________ ***Ethnicity:*** **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐

Address: ____ **City:** ___________________ **State:**_________ **Zip:**________________

Employer: __________________________________ **Occupation:** ___________________________ **Work #:** ___________________

Home #: _____________________**Cell #:** ______________________ **E-Mail:** ____

Primary Care Physician: __________________________________ **PCP Location (city/state)**__________________________________

Emergency Contact: __________________________________ **Phone:** __________________ **Relationship:** ___________________

RESPONSIBLE PARTY

Name: ________________________________ **DOB:** ____/____/____ **SSN:** _______-______-_______ **Phone:** __________________

Address: ____ **City:** ___________________ **State:**_________ **Zip:**________________

MEDICAL INSURANCE

(Please present your insurance cards for scanning)

Primary: _______________________ **Subscriber:** _____________________ **DOB:** ____/____/____ **ID#:** _____________________

Subscriber Relationship: _____________________ **Employer:** _________________________ **SSN:** _______-_____-______

Secondary: _______________________ **Subscriber:** _____________________ **DOB:** ____/____/____ **ID#:** ____________________

Subscriber Relationship: _____________________ **Employer:** _________________________ **SSN:** _______-_____-______

VISION INSURANCE

(Please present your insurance cards for scanning)

Primary: _______________________ **Subscriber:** _____________________ **DOB:** ____/____/____ **ID#:** _____________________

Subscriber Relationship: _____________________ **Employer:** _________________________ **SSN:** _______-_____-______

Secondary: _______________________ **Subscriber:** _____________________ **DOB:** ____/____/____ **ID#:** ____________________

Subscriber Relationship: _____________________ **Employer:** _________________________ **SSN:** _______-_____-______

ARE WE BILLING: **Worker's Comp:** ☐ **Date Occurred:** ____/____/____ **Ins. Co.:** ________________ **Claim #:** _________________

Auto Insurance: ☐ **Date Occurred:** ____/____/____ **Ins. Co.:** ________________ **Claim #:** _________________

How did you hear about us?

Phone Book: ☐ **TV:** ☐ **Radio:** ☐ **Insurance List:** ☐ **Friend:** ☐ **Relative:** ☐ **Newspaper:** ☐ **Internet search:** ☐ **Other**________

All professional services rendered are charged to the patient or responsible party. We will file claims with patient's insurance carrier: however, the patient is responsible for all fees, co-payments, and/or insurance deductibles, as well as any amount not covered by insurance. **Payment of co-payments and insurance deductibles is expected when services are rendered unless other arrangements have been made in advance.** **FOR MEDICARE PATIENTS:** I request that payment of authorized Medicare benefits be made either to me or to the proved names above for an services furnished me. I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine these benefits or benefits for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on the approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The provider accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier. Our practice may refer you to an entity in which the referring practitioner has a financial interest; you have the right to choose any facility, diagnostic lab or practitioner.

I further give my permission for the release of information regarding my diagnosis, test results and/or prescriptions to my telephone/text number or to leave a message on my voice mail. I also permit you to contact me by e-mail.

I hereby assign to the physician, if assignment is taken, all payments for medical service rendered.

I have been offered a copy of the HIPAA Privacy Practices.

I give my permission for affiliates of Oregon Eye Associates to speak to ____________________________/_________________regarding my healthcare

(Name) (Relationship)

Date:___/___/___ **Signature:**__________________________________**Printed Name:**______________________________

Patient Signature(Parent or Guardian if patient is a minor)