EYECARE ASSOCIATES

Welcome Back to Our Office

Name: _____ Date of Birth: _____

Preferred Name: _____ SSN: _____

Mailing Address: _____ Employer: _____

City: _____ Zip Code: _____ Occupation: _____

Phone Number:_____ Marital Status: _____

Cell Phone Home Phone Spouse: _____

Do you accept text messages? Yes or No Primary Care Physician: _____

Email: _____

Financial Responsibility

It is our office policy to inform you of our payment procedures. Please review and initial the section below that is applicable. **All accounts not paid within 60 days are subject to 1.5% interest charge.**
Contact lens services fees are subject to additional fees that are not listed below.

_____1. **Patient without insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangement must be made with our billing department prior to your visit.

_____2. **Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services (such as the **Optomap** which is $45), co-insurance, and items considered "not medically necessary" by your insurance company. Please note that copayments and coinsurance amounts are due at time of service. The remaining balance should be taken care of within one(1) month of notice from the insurance company unless other arrangements are made with our billing department. If you or your insurance carrier make payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the billing department to make other arrangements.

_____3. **Medicare**

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services such as the **refraction ($25)** and the **Optomap ($45)**.

I have read and agree to the financial policy information stated above that applies to me.

_____ _____
Patient (or responsible party) signature Date

_____ _____
Person signing on behalf of patient (please print name) Relationship to patient

Brian Mitchell, OD | Tessa Johnston, OD | Damon Hanson, OD
935 Royal Ave Medford, Oregon 97504 | Phone 541-779-2211 | Fax 541-779-8778 | www. EyeCareSouthernOregon.com

EYECARE ASSOCIATES

HIPAA CONSENT: PATIENT PRIVACY

We are required by law to protect the privacy of your medical information, and to provide you with written notice describing how medical information about you may be used and disclosed, and how you can access this information.

We may use or disclose to others your medical information for purposes of providing or arranging for your health care and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances, we may need our written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining and accounting of our disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time.

You have the right to receive a copy of your most current Notice of Privacy Practices in effect. If you wish to receive a copy, please ask at the front desk, and we will provide you with a copy.

I consent to Eyecare Associates of Southern Oregon, PC's Notice of Privacy Practices

Patient Name: _____

Signature: _____ Date: _____

Please list anyone you wish to have access to your records:

1. _____ 2. _____

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