LIVE OAK
OPHTHALMOLOGY
Darrell E. Hester, M.D. • Brian J. Groat, M.D.

PATIENT REGISTRATION

Date:_____

Patient's Name _____ DOB _____ Sex M F Marital Status S M W D

Home Address _____ E-mail address _____

City _____ State _____ Zip Code _____ SSN# _____

Phone (H)_____ Phone (W) _____ Phone (Cell) _____

Emergency contact_____ Relationship _____ Phone _____

Patient Employer_____

Spouse's Name _____ DOB _____ Employer _____

Primary Care Physician _____ Optometrist/Ophthalmologist _____

Ethnicity: _____ Race: _____ Language: _____

RESPONSIBLE PARTY INFORMATION ~ COMPLETE ONLY IF DIFFERENT THAN INFORMATION GIVEN ABOVE

Name _____ SSN _____ DOB _____

Address _____

Phone (H) _____ Phone (W) _____ Phone (Cell) _____

INSURANCE INFORMATION

Primary Insurance _____

Name of Policy Holder _____ Policy Holder DOB _____

Relationship to Policy Holder _____

Secondary Insurance _____

Name of Policy Holder _____ Policy Holder DOB _____

Relationship to Policy Holder _____

I authorize the release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Live Oak Ophthalmology, PC.

_____

Signature of Patient or Responsible Party:

_____

Please Print Name: Date:

Patient Acknowledgement Regarding Precautions Following Dilation

It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend not driving or operating dangerous machinery immediately after dilation. We recommend that someone drive you home or that you wait until your eyes return to normal so that you can drive safely.

Refraction Service and Fee

· A refraction is necessary to determine the performance of the visual system and is an essential part of the medical eye exam. Although a refraction is also used to determine the need for corrective eyeglasses or contact lenses, this practice performs refractions as a necessary part of the medical exam. Refraction is also necessary to evaluate a patient for surgery. Unfortunately, **some insurance plans (including Medicare) DO NOT cover the cost of refractions. In these cases, the patient will be responsible for the refraction charge.**

· A refraction is NOT a covered service by Medicare or some insurance plans.

· Our practice will not file the charge for a refraction with a health insurance plan unless we have verification that your insurance plan covers the cost of the refraction.

· If your plan does not cover the refraction you will be responsible for paying the $40.00 refraction fee at the time of service in addition to any copayment your insurance plan may require.

Non-Covered Services

As our patient, we want to provide you with the best care possible. There may be certain services we feel are necessary for the maintenance of good health that will not be covered by your insurance company contract. ***You will be expected to pay for any non-covered services.*** Please be assured we will order only those tests and perform only those services that are necessary for your treatment and care. We will notify and discuss with you as we progress with your treatment any services we feel may not be covered although we may not always know for certain how your insurance company will process your claim.

Please note that verifying insurance coverage is your responsibility. If you have a question about your coverage, please contact your insurance provider directly. If we file a claim and it is denied because our services are not covered under your insurance plan, you will be billed directly for all costs associated with your visit.

I have read and understand the above information. I accept full financial responsibility for the cost of any uncovered services if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have is separate from and not included in these fees. I also understand that an additional $30 collections fee will be charged to any account that is turned over to the collections agency for non-payment of services.

Patient's Name (Printed)	Date	Patient's Signature

How did you hear about our practice?

_____ Previous Patient _____ Family Member _____ Friend _____ Other

_____ Insurance Company _____ Yellow Pages _____ Newspaper _____ Internet