SOUTHERN EYE ASSOCIATES

EYE SURGERY CENTER OF ARKANSAS

PATIENT INFORMATION

Date _____

Name_____
LAST FIRST MI

Mailing Address_____

City, State, Zip_____

Phone # Home _____ Cell_____ Birthdate _____ Age _____ Sex _____

Marital Status S M W D SS# _____ Email Address _____

Employer _____ Phone _____

Parent or Spouse Name _____ Employer _____

Birthdate _____

Person to Contact in Case of Emergency _____

Relationship to You _____ Emergency Phone _____

Were you referred by a doctor? _____ If so, who? _____

Who is your family doctor or PCP (Primary Care Physician)? _____

Who is your regular Optometrist?_____

WE ASK THAT YOU ALLOW US TO MAKE COPIES OF YOUR INSURANCE CARDS.

****Please read and sign below***

I have received the Notice of Privacy Practices, Patient Rights and Notice of Ownership for the practice and/or surgery center.

I acknowledge that all information on this form is accurate and up-to-date.

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED. IF YOU DO NOT HAVE MEDICAL INSURANCE THEN ARRANGEMENTS MUST BE MADE IN ADVANCE FOR PAYMENT. WE ACCEPT ASSIGNMENT ON MEDICARE, MEDICAID, AND ARKANSAS BLUE CROSS/BLUE SHIELD. PATIENTS WILL BE RESPONSIBLE FOR ANY MEDICARE OR INSURANCE DEDUCTIBLE AND THEIR CO-INSURANCE AMOUNTS.

SIGNATURE_____ DATE_____

Please read and complete back of form

601 East Matthews • Jonesboro, AR 72401 • (870) 935-6396 • Toll Free 1-800-634-7299 • FAX (870) 935-4063

AGREEMENT OF RESPONSIBILITY

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to **Eye Surgery Center of Arkansas/Southern Eye Associates** for any services furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents or other insurance any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the change determination of the Medicare contractor, and I am responsible for all deductibles, co-insurance of any amount insurance does not pay, and for any non-covered services.

RELEASE OF INFORMATION

The **Eye Surgery Center of Arkansas/Southern Eye Associates** is authorized to furnish information from the patient's medical record to any insurer, compensation carrier, or welfare agency who may be providing financial assistance for **Eye Surgery Center of Arkansas/Southern Eye Associates** care. The patient indemnifies the **Eye Surgery Center of Arkansas/Southern Eye Associates** and holds it harmless from any and all damage or prejudice which might result to the patient or his/her relatives or heirs from use or misuse by the insurance company of the information turned over to it by the **Eye Surgery Center of Arkansas/Southern Eye Associates** pursuant to the patient's written authorization.

I hereby authorize **Eye Surgery Center of Arkansas/Southern Eye Associates**, its agents, affiliates and employees to have access to my medical records for the purpose of performing its billing and collection, administrative, financial, and business functions.l

MEDIGAP OR OTHER SECONDARY INSURANCE

I also request that the payment of authorized Medigap benefits or other secondary insurance be made either by me or on my behalf to **Eye Surgery Center of Arkansas/Southern Eye Associates,** or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer any information needed to determine these benefits payable for related services. I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

If this account is assigned to a collection company an additional fee of 50% the owed amount will be added to the balance.

Patient's Signature	Date / / Time	Witness Signature
Legal Guardian's or Power of Attorney *Consent (if applicable)*	Relationship to Patient	Policy Holder's Signature