Patient Information — Aurora Eye Clinic, Ltd

Today's Date:	**Primary Care Physician:**		**Phone #:**
	Primary Care Physician Address:		

Patient's Last Name:	First:	Middle:	Marital Status : (Circle One) Single / Married / Divorced / Widow

Birthdate:	Age	Sex: (Circle One) M F	**Race: (required)**	**Language: (required)**	**Ethnicity: (Circle One)** Not Hispanic Hispanic Chinese

Street Address:	Social Security #:	Home Phone #:

City:	State:	Zip:	Cell Phone #	Work Phone #

Email Address:	**Employment Status: (Circle One)** Employed Unemployed Retired Student Disabled

Employer:

Employer Address:	City:	State:	Zip:

Spouse's Name:	Spouse's Date of Birth:

How did you hear about us? ☐ Insurance ☐ Yellow Pages ☐ Physician (name) ____________________________________

☐ Friend/Relative (Name) _____________________________________

☐ Hospital (Name)____

Complete if Patient is covered under Parent's insurance or Legal Guardian

Father's Name (legal guardian):	Social Security #	Employer:
Father's Address:		Father's Phone #
Mother's Name (legal guardian):	Social Security #	Employer:
Mother's Address:		Mother's Phone #:

INSURANCE INFORMATION **PLEASE BRING INSURANCE CARDS TO FRONT DESK**

Primary Insurance Name:	Policy #	Copay Amt.
Name of Policyholder:	Social Security # of Policyholder	***Birthdate of Policyholder***
Secondary Insurance Name:	Policy #	Copay Amt.
Name of Policy Holder:	Social Security # of Policyholder	***Birthdate of Policyholder***

IN CASE OF EMERGENCY

Name of local friend or relative:	Phone # (home)	Phone # (work)	Phone # (cell)

Patient Name: ______________________

Aurora
EYE CLINIC, LTD.

DILATION

I also acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it may be best if you make arrangements not to drive yourself. Please ask for assistance if your vision is markedly affected.

FINANCIAL ASSIGNMENT AND AGREEMENTS

- I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Aurora Eye Clinic for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

- **Collection Policy** – I understand that I am financially responsible for the timely payment of all charges not covered by insurance. Unless I make prior arrangements, I will pay "out of pocket" charges on the day of service. In the event your account is referred for outside collection, you agree that you shall be responsible for all costs of collection, including all court costs and attorney's fees. It is further understood and agreed that any attorney's fees or collection fees incurred by Aurora Eye Clinic in its efforts to collect your unpaid account will be charged to and added to your unpaid account balance.

- I am aware that my HMO Insurance requires a referral and /or prior approval for treatment and I am aware that if a referral/authorization is not present at the time of treatment, I am financially responsible for charges related to that visit.

- Medical insurances (example: Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.

- I authorize Aurora Eye Clinic to communicate with me by phone, answering machine, letter or email at home or business regarding appointments, care or billing.

- I agree to the release of my medical information to my personal physician(s), or optometrist(s).

I acknowledge that a copy of **Aurora Eye Clinic's Notice of Privacy Practices** has been provided to me for review and that a copy is available at my request.

Signature: ____ Date: ____________

(Patient, legal guardian or authorized party)