Medical Center Eye Associates at Coulter Drive Optical

Anthony V. Bass, O.D., P.A
Diplomate of the American Board of Optometry
Therapeutic Optometrists specializing in Glaucoma
Tyler C. Smith, O.D., P.A.
Therapeutic Optometrists specializing in Glaucoma

Patient's Information:

Patient Name: _____ **Nick Name**: _____
Date of Birth: _____ **Sex**: ____ **Social Security #**: _____
Single: _____ **Married**: _____ **Widowed**: _____ **Spouse's name:** _____
Race: American Indian Alaskan Native Asian Black or African American Hispanic
Native Hawaiian Pacific Island White Other: _____
Preferred Language - English Spanish or Other: _____
Communication Preferred - E-mail Postal Telephone or Text
Address: _____ **Apt**: _____
City: _____ **St**: _____ **Zip**: _____
Home#: _____ **Cell#**: _____ **Work#**: _____
E-mail address: _____

Patient Occupation: _____ **Employer**: _____
Vision Insurance: _____
Medical Insurance: Primary_____ **Secondary**_____

Policy Holder/Legal Guardian's Info:

Name: _____ **Social Sec #**_____
Date of Birth: ____/____/____
Address: _____ **Apt:** _____ **City**: _____
State: _____ **Zip Code**: _____

How did you hear of us? Friend / Family (Name): _____
Yellow Pages: _____ Insurance: _____ Website: _____ Facebook: _____ Other: _____

ADVANCED BENEFICIARY NOTICE

Notes: Most Insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. We **do not** guarantee the accuracy of benefit information given to us by insurance companies.
Please understand that financial responsibility for your account is yours, not your insurance company's

I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical or vision benefits to the physicians or supplier for services rendered.
I understand that I am responsible for any balance my insurance does not pay.
All above is correct to the best of my knowledge.

Signature: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Coulter Drive Optical make every effort to inform you of your rights related to your personal health information. Please Check **ONE:**

- ☐ I have read or had explained to me Coulter Drive Optical Notice of Privacy Practice and agree to continue my care with Coulter Drive Optical under said terms.
- ☐ I was given the opportunity to read Coulter Drive Optical Notice of Privacy Practices and declined but wish to continue my care with Coulter Drive Optical under the terms of Coulter Drive Optical privacy policies.
- ☐ I have read or had explained to me Coulter Drive Optical Notice of Privacy Practice and do not wish to continue my care with Coulter Drive Optical under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient

Starting November 1, 2018

We will no longer be refunding money less than $50.00, any over payment less than $50.00 will be applied to the patient's account. If you desire to have a refund mailed to you, please call the office.

_____ _____
Signature Date