Capital Eye Medical Group,Inc.
Mitra Ayazifar, MD

PATIENT DEMOGRAPHICS

Mr/Mrs/Ms Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

Apt/Box: _____ Cell Phone: _____

City:_____ Social Security #: _____

State: _____ Zip: _____ Email: _____

MALE FEMALE Marital Status: Single * Married * Other Spouse Name: _____

Occupation: _____ Referred By: _____

RESPONSIBLE PARTY/GUARANTOR DEMOGRAPHICS

Name:_____ Date of Birth: _____

Address: _____ Home Phone: _____

Apt/Box: _____ Cell Phone: _____

City:_____ Social Security #: _____

State: _____ Zip: _____ Email: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured SS#:_____

Insured Birth Date: _____

Employer: _____

Insurance Co Name: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured SS#:_____

Insured Birth Date: _____

Employer: _____

Insurance Co Name: _____

WORKER'S COMPENSATION INFORMATION

Is this a worker's Comp: YES or NO If Yes, Date of accident: _____ Employer Notified: YES or NO

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **RELEASE OF INFORMATION:** I understand and authorize **Capital Eye Medical Group** to disclose the PHI necessary for reimbursement of services rendered under Treatment, Payment, and Operations to my insurance(s), Worker's Compensation and Health Care Financing Administration any information about me needed to determine these benefits or the benefits payable of my bill.
2. **INSURANCE AGREEMENT** Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Capital Eye Medical Group** for any services furnished to me by their physicians. If co-payments and/or deductibles are designated by my insurance company or my health plan I agree to pay them to **Capital Eye Medical Group**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **Capital Eye Medical Group**, if I belong to a plan that is not on their list of contracts.

   NON-COVERED SERVICES: I understand that Capital Eye Medical Group, contracts with health care service plans (i.e. HMO's, PPO's) relate only to items and services, which are "covered" by the health care service plans.

PLEASE TURN OVER TO COMPLETE…

Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services such as Refractions, Corneal Topography, Pachymetry; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Capital Eye Medical Group, to obtain necessary health care service plan authorizations.

3. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Capital Eye Medical Group, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Capital Eye Medical Group, for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.
4. **REFRACTIONS:** In most cases you will be responsible for the "**Refractions**". This service is the determination of the need for glasses or change in your current glasses prescription. This is considered a "**Non-Covered**" service by Medicare, or routine care. Most secondary carriers do not cover this service since Medicare does not allow it. Therefore, payment is due from you upon completion of your eye examination for the "**Refraction**". We will still submit this charge to your primary and secondary insurance.

I HAVE READ, UNDERSTAND AND AGREE WITH THE RELEASE OF INFORMATION, INSURANCE AGREEMENT, NON-COVERED SERVICES, FINANICAL AGREEMENT AND REFRACTIONS LISTED ON THE FRONT AND BACK OF THIS DOCUMENT.

_____ _____

PATIENT BENEFICIARY/RESPONSIBLE PARTY/GUARDIAN SIGNATURE **DATE**

FUTURE PATIENT DEMOGRAPHIC CHANGES

Date: _____ Changes: YES or NO _____
Patient/Responsible Party/Guardian

Date: _____ Changes: YES or NO _____
Patient/Responsible Party/Guardian

Date: _____ Changes: YES or NO _____
Patient/Responsible Party/Guardian

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Patient/Responsible Party/Guardian

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Patient/Responsible Party/Guardian