# LAUDERDALE EYE SPECIALISTS

Patient Name._____Today's Date_____
Last First Middle

Home Address_____

City_____State_____Zip Code_____

**Is this visit related to an auto accident? [ ] Yes [ ] No Are you currently in skilled nursing facility? [ ] Yes [ ] No Hospice? [ ] Yes [ ] No**

**Do you consent to have your photo taken? [ ] Yes [ ] No**

Home Phone_____ Cell Phone_____

Work Phone_____ ***Preferred #***_____

E-mail address_____ May we text and/or leave messages on voicemail? **[ ] Yes [ ] No**

May we send correspondence and/or statements to above email? **[ ] Yes [ ] No** Marital Status: Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Employer _____Occupation_____

Referred by: _____Patient(s) of our office? [ ] Yes [ ] No

Emergency Contact_____Phone_____

Do you give us permission to discuss your care and/or billing matters with the emergency contact listed? **[ ] Yes [ ] No**

Primary Care Physician_____Phone_____

Pharmacy Name_____Phone_____

Primary Insurance _____ID#: _____

Policy Holder _____Policy Holder's D.O.B. _____

Policy Holder's Social Security #: _____Relationship to Patient: _____

Secondary Insurance: _____ID#: _____

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to James Lang, MD, PA to be applied to my account for services rendered by our physicians. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I authorize the release of any information requested by my insurance carrier pertaining to any claim filed. I authorize the practice to submit appeals on my behalf. This is a lifetime signature and will be kept on file for all future claims. I certify that the information given by me is true and correct. I have reviewed the Notice of HIPAA Privacy Policy. I authorize Lauderdale Eye Specialists to obtain or release any and all pertinent information regarding my medical care and insurance information as needed, to assist in my ongoing treatment to or from other health care providers.

_____ _____

**Patient's signature** **Date**

## REFRACTION POLICY

The REFRACTION is an eye exam that measures a person's prescription for eyeglasses. It is also the most precise method in which the doctors can determine that your eyes are corrected for the best vision possible. If you are a new patient here, baseline refraction will most likely be performed today if you are not seeing 20/20 with your present glasses or contacts. If you are an established patient and your vision is found to have decreased since your last refraction, a new refraction is recommended. You may or may not be given a prescription for new glasses based on the result of your refraction. In the past, refractions were included in your complete eye exam. Since 1998, Medicare notified us that we can no longer include the refraction as part of your eye exam, and that we are required to charge. The fee is $65.00 for this service. I understand that if a refraction is done in this office it is a non-covered service and payment is expected from me at time of service.

_____ _____

**Patient's signature** **Date**