ORANGE COAST
eye center

Patient's Name _____ Male Female Other **S/W/M/D Date of Birth** _____
FIRST M.I. LAST

Legal Guardian if Patient is Minor _____ **Date of Birth** _____
FIRST M.I. LAST

Address _____ **Social Security Number** _____
STREET CITY ZIP CODE

E-mail _____ **Driver's License Number** _____

Home Telephone No. _____ **Cell Phone No.** _____

Spouse's Name _____ **Date of Birth** _____

Employer _____ **Occupation** _____

Employer's Address _____ **Telephone No.** _____
STREET CITY ZIP CODE

Person to Contact In Case of Emergency _____
NAME PHONE NUMBER RELATIONSHIP

Referred By _____
NAME ADDRESS PHONE NUMBER

Primary Care Doctor _____
NAME ADDRESS PHONE NUMBER

Do you have a Vision Plan? Yes_____ No_____
(If YES and you wish to use your Vision Plan today, then you must schedule an appointment with our Optometrist)

Do you reside in a skilled nursing facility? Yes _____ No _____

Are you in a hospice program? Yes _____ No _____

SIGNATURE OF PATIENT _____ **DATE** _____
(or legal guardian)

I verify that the above information is correct, and I notified the receptionist of any changes to my personal or insurance information.

_____

INITIAL **DATE**

Jared R. Younger, M.D., M.P.H.
Board Certified Ophthalmologist / Laser Cataract Surgery

Mark A. Bronstein, M.D., M.M.M.
Board Certified Ophthalmologist / Retina & Vitreous

(714) 546-2020
18426 Brookhurst Street, Suite 105 / Fountain Valley, CA 92708 / www.OrangeCoastEyeCenter.com

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I authorize the release of any medical information to my insurance carrier that is necessary to process this, and all future claims submitted. I permit a copy of this authorization to be used as the original for all current and future claims submitted. I hereby authorize my insurance company to pay by check issued and directly mailed to:

Orange Coast Eye Center
18426 Brookhurst St. Ste 103
Fountain Valley, CA 92708

I understand the Orange Coast Eye Center ophthalmologists are licensed and regulated by the Medical Board of California. NOTICE TO COMSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. (800)633-2322 www.MBC.CA.GOV

Date _____ Signature of Patient, Spouse, Guarantor or Parent _____

I acknowledge Orange Coast Eye Center's Notice of Privacy Practices. I understand the Private Practice is available to me and understand its purpose and stipulations.

Date _____ Signature of Patient, Spouse, Guarantor or Parent _____

I understand that additional medical testing(s) could be recommended during my exam and I am aware that I may be responsible for all or part of the testing charges, depending on my insurance coverage.

Date _____ Signature of Patient, Spouse, Guarantor or Parent _____

Beneficiary Signature for Medical Electronic Billing

I request the payment of authorized Medicare Benefits to be made on behalf of the patient to Orange Coast Eye Center for services furnished to me. I permit a copy of this authorization to be used in place pr the original and authorize determine benefits payable for these services rendered.

Date _____ Signature of Patient, Spouse, Guarantor or Parent _____

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FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, ANY AND ALL FINANCIAL LIABILITY RESTS WITH THE PATIENT. Our office participates with most major insurance plans (VSP,MES,SUPERIOR/EYEMED).

MEDICAL INSURANCE: Any medical complaint and all diagnostic tests of the eyes must be billed to your medical insurance ONLY. You are responsible for any discrepancies between our fees and the amount your insurance carrier pay for services rendered in our office (Deductible, Copayment, Co-insurance). A **refraction** (a test that determines one's prescription in order to prescribe glasses) **is NOT a covered medical service by most insurance companies including Medicare.** If you receive a prescription for glasses, you will be charged $55 which is due at the visit. This policy includes refractions after eye surgery. Also, if you request a contact lens fitting, there will be a charge for time and trail lenses, ranging from $75-$250, which medical insurance does not cover. This is considered separate from the refraction.

VISION INSURANCE: Routine eye exam and refractions are not covered by Medicare and most medical insurance plans. These vision services are covered under vision insurance, not medical plans. Our office will do its best to find out if you currently have a vision plan, however if you find out after your visit that you are currently enrolled in a vision plan we cannot change who was billed for the exam visit. It is **Patient's responsibility** to know what insurance they have prior to the exam with our doctors.

OPTICAL (Glasses and Contact Lenses): Glasses are custom ordered. Therefore, you must put a deposit down of half or greater in order for your glasses to be made. Since vision plans use contracted labs, we cannot change privately paid spectacle order to a Vision plan once processed, nor issue a refund once the order is submitted. Patients have 60 days to recheck their glasses prescription. After 60 days, there will be another $55 refraction fee. All Contact lens orders are payable at the time the order is placed.

It is the patient's/parent's/guardian's responsibility to:
-Be familiar with the benefits of your plan, including copays, coinsurance, and deductibles.
-Bring all your current insurance cards to all visits.
-Provide our office with current information including address, phone numbers and primary care physician.
-In accordance with our insurance contract, **you must pay copay/deductible/coinsurance at each visit.** If you do not make your payment, you will be charged an additional **$10 billing fee** if we do not receive payment within 10 days. We accept cash, checks, and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to make a payment plan with you. Any payment made by check that does not clear your bank account will result in a $25 fee, which will be added to your account and must be paid before the next visit. If necessary to submit your account to a collection agency, you will be liable for the full balance and collection expenses. There may be additional fees for medical record copies and completing any patient forms, including DMV or disability forms.

I have read and understood the above financial policy.

Signature of Patient/guardian/parent Date

_____ _____

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Authorization to Release Healthcare Information

Patient Name:_____ DOB:_____

I request and authorize **Orange Coast Eye Center** to release healthcare information of the patient named above to:

Name:_____

Relationship:_____

Phone #:_____

This request applies to the following:

- ☐ Health information such as appointments,diagnosis,treatment and medication
- ☐ Billing
- ☐ All
- ☐ Other:_____

I give my consent to release any medical or any information checked above

Patient's Signature:_____

Date:_____

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