Thank you for choosing Miles Eye Care
We hope that you enjoy your visit with us today!

Patient Information Form

Last Name ______________ First ________ MI ____ Preferred name ________

Title: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other ______ Marital Status: S M W D

Address ____________________ City __________ State ____ Zip______

Cell ______________ Home ______________ Work ______________

Social Security ______________ Birthdate (mo/day/year) _____/_____/_____

Email Address: ______________________________

We may need your email address to send you your clinical summaries and patient educational materials.
We will not sell or disclose your email address to anyone.

Employer: ______________________ Position: ______________

Contact at work: Y ☐ N ☐ Work Phone ____________ Ext ________

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*Payment is due at the time services are rendered. Please have your insurance cards available. If we are in network with your insurance, we will collect all co-pays and non-covered fees. If we are not in your insurance network, we will collect payment in full and be happy to assist you in submitting a claim to get you reimbursement if available.

Person Responsible for Billing (if different from above)

Last Name ______________________ First ____________ MI ____

Address ____________________ City __________ State ____Zip______

Cell ______________ Home ______________ Work ______________

Social Security ____________ Birthdate (mo/day/year) _____ /_____ /_____

Employer ________________ Work Phone __________ Ext ______

Emergency contact

Name: (closest relative or friend) ______________________________

Relationship to Patient ______________________ Phone ____________

Referral Information

How did you hear about our office? ______________________________

May we thank someone for referring you? ______________________________

Today's Date ____________________ Updated ____________________

Insurance

(Please complete all information even if a copy of your insurance card(s) was provided)

Vision Insurance Information

Primary Vision ____________________
Insured's Name ____________________
Insured's Date of Birth ____________________

Secondary Vision ____________________
Insured's Name ____________________
Insured's Date of Birth ____________________

Medical Insurance Information

Primary Medical ____________________
Insured's Name ____________________
Relationship to Patient ____________________

Insured ID ____________________
Insured's Employer ____________________
Insured's Date of Birth ____________________

Secondary Medical ____________________
Insured's Name ____________________
Relationship to Patient ____________________

Insured ID ____________________
Insured's Employer ____________________
Insured's Date of Birth ____________________

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf to Miles Eye Care for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. My signature authorizes releasing the information to the insurer or agency shown. I further authorize releasing information to all insurance companies including Medigap policies. Miles Eye Care may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation 1) which is or may be liable or under contract to for the reimbursement for services rendered, and 2) any healthcare provider for continued care. This authorization remains in effect until withdrawn by me.

I understand that if I default in paying my account balance in a timely manner, I will be turned over to a **third-party collection agency,** and I will be responsible **for up to a $75.00 late fee ($25.00 late fee per month),** and court costs and lawyer fees.

Signature X ____________________ Date: ____________________

HIPAA Privacy and Patient Contact Information

By listing the persons below, I am authorizing that the doctors/staff to be able to (without requiring your presence) discuss your case, answer questions, leave detailed messages and also contact, in the event of an emergency, the person(s) you list below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization if optional and can be withdrawn by you in writing at any time.

Others to whom we may share information about your healthcare:

Name ____________________
Relationship ____________________
Phone ____________________

Name ____________________
Relationship ____________________
Phone ____________________

Name ____________________
Relationship ____________________
Phone ____________________

☐ Self Only

By signing below, I acknowledge that I have received HIPAA Notices of Privacy Practices and give permission to Miles Eye Care to share information with any persons listed above.

Signature X ____________________ Date: ____________________