

PATIENT INFORMATION Please **PRINT** In **BLACK** Ink

Patient ID# _____

Patient's Name: _____ Date of Birth: _____ Age: _____
First Initial Last
 Social Security #: _____ Sex: []M []F Marital Status: []Married []Single []Divorced []Widowed
 Mailing Address: _____ City, State, Zip: _____
 E-mail Address: _____ County: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 May we leave a message at your home or cell number? Yes No
 Occupation: _____ Employer: _____ Phone: _____
 Referring Physician: _____ Personal/Family Physician: _____
 Spouse's Name: _____

RESPONSIBLE PARTY INFORMATION (If different than above)

Responsible Party: _____ Patient Relationship: _____
 Date of Birth: _____ Social Security #: _____
 Address: _____ City, State, Zip: _____
 Employer: _____ Phone: _____

EMERGENCY CONTACT Please give name and phone number of a friend or relative that does not live at your present address.

Name: _____ Phone: _____
 Relationship: _____

Person(s) with who(m) we may share your healthcare information: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Name: _____	Insurance Name: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID#: _____	Subscriber ID#: _____
Date of Birth: _____	Date of Birth: _____
Group Number _____	Group Number _____
Certificate Number _____	Certificate Number _____

Insurance Authorization and Assignment (PLEASE READ)

I authorize Oregon Trail Eye Center, P.C. to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution and other healthcare operations to appropriate agencies, including collection agencies, insurance companies and third party payers.

I request that payment of medical benefits be made on my behalf to the Oregon Trail Eye Center PC for any services provided to me by Shawna R. Collier, MD, Keegan A. Harkins, MD, Brian L. Colburn, OD, and/or Jared Smedley, MD. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other Health Care Organizations and it's agents any information needed to determine their benefits. I understand that if the balance is my responsibility.

I authorize treatment of the person named above, I CERTIFY THAT I AM THE PATIENT OR LEGAL GUARDIAN OF THE PATIENT, and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless credit arrangements are made. I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable. All past due accounts will be charged 10% interest per year. The above information is for the purpose of extending credit and is warranted to be true.

X _____ X _____
 Patient / Responsible Party Signature Date



Authorization to Release Information to Family, Friends, or Legal Representative

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

This Authorization to Release Information is for:

Patient's Name: _____ Date of Birth: _____ Medical Record Number: _____

I authorize Oregon Trail Eye Center to release my records and any information requested to the following individuals:

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____
3. _____ Relationship: _____ Phone: _____
4. _____ Relationship: _____ Phone: _____

_____ I DO NOT wish to disclose my information to anyone.

Authorization Regarding Messages
(Please check any that apply)

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments

_____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

_____ I authorize you to leave a message with anyone who answers the phone

_____ Messages may only be left with _____

Patient's Signature _____ Date _____

Parent/Legal Guardian/P.O.A. Signature _____ Date _____



FINANCIAL POLICY

Thank you for choosing OTEC for your eye care. We are committed to providing you with high quality and technologically advanced care.

- 1. Registration:** All patients must complete our patient information form to facilitate communications and billing. We must obtain a copy of your driver's license, or photo ID, and valid insurance card(s). Failure to provide OTEC with current patient or insurance information, may result in the patient being responsible for the balance of a claim.
- 2. Insurance:** Your insurance benefit is a contract between you and the insurance company; we are not a party to that contract. Knowing your insurance terms, including deductibles, copays, coinsurance, and maximum out-of-pocket amounts, as well as your benefits, including covered and noncovered services, is your responsibility. We participate in many insurance plans to facilitate payment for our patients.
- 3. Patient payment:** All copayments and deductibles are to be paid at the time of service.
- 4. Insurance Claims:** The Assignment of Benefits (AOB) allows us to submit, make corrections to, and receive payment for, your insurance claims. Please be aware that the balance of your claim is your responsibility, whether your insurance company pays or not. You will receive a monthly statement of any self-pay balance that is due upon receipt. Any account balance over 90 days will be subject to review for collection action.
- 5. Uninsured patients:** We offer a 10% discount to our uninsured patients when the charges are paid in full at the time of service. Otherwise, you will receive a monthly statement that is due upon receipt. Partial payments will not be accepted unless otherwise negotiated. Any account balance over 90 days will be subject to review for collection action.
- 6. Collection:** Please be aware that accounts deemed uncollectible by OTEC will be sent to a collection agency.

I have read and understand the financial policy and agree to abide by its guidelines.

Patient Name:

X _____ Date:
Signature of patient or responsible party including relationship

Medicare Secondary Payer Questionnaire

(Short Form)

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. Are you receiving benefits from any of the following programs?

- Black Lung YES (Long form Part I) NO
 Research Grant YES (Long form Part I) NO
 Veteran Affairs YES (Long form Part I) NO

2. Was illness/injury due to a work related accident/condition?

- YES NO

If **YES**, answer the following:

- Work related accident (complete Part I of long form).
 Non-work related accident (complete Part II of long form).

3. Is the patient currently employed?

- YES (answer next question) NO

Do you have group health plan (GHP) coverage? If yes, are there under or over 20 employees?

- OVER (Long form Part IV) UNDER

4. Is the patient's spouse currently employed?

- YES (answer next question) NO

Does your spouse have group health plan (GHP) coverage? If yes, are there under or over 20 employees?

- OVER (Long form Part IV) UNDER

5. Is the patient entitled to Medicare benefits as a result of:

Age _____

End Stage Renal (Kidney) Disease? YES (Long form part VI) NO

Disability? YES (Long form part V) NO

6. Are you currently a patient in a skilled nursing facility such as a nursing home?

(Long form not required, ALERT: If yes bill SNF not Medicare)

- YES NO

I confirm that the above information is correct.

Patient Name: _____

Date: _____

Patient Signature: _____