THE OFFICE OF:

Medina Eye Care

CERTIFIED THERAPEUTIC AND GLAUCOMA SPECIALIST

CONFIDENTIAL PATIENT INFORMATION
DATE: ____/____/____

PLEASE PRINT

Dr. Mr. Mrs. Ms. Miss _____ Male Female

Address: _____ *City/State:* _____ Zip: _____

Hm Ph: _____ Cell Ph: _____ Work Ph: _____ Employer/ School: _____

Age: _____ D.O.B.: _____/_____/_____ *SS#:* _____-_____-_____ Marital Status: _____

Email Address: _____ Preferred Method of Contact: _____

Primary Care Physician: _____ Date of Last Visit: _____

Referred by: Insurance Referring Doctor Website Google Friend/Family Member

Patient: _____ Doctor: _____ Other: _____

Spouse's Name: Employer:

Hm Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

If patient is a child or adolescent, please provide the follow information:

Parent/ Legal Guardian: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email: _____

AS A COURTESY, WE WILL FILE MOST INSURANCE CLAIMS WHEN YOU COMPLETE THE SECTION BELOW AND PROVIDE THE FOLLOWING:

1. Photocopies of the front and back of your valid insurance ID card.
2. Downloaded or printed description of your medical and/or vision benefits.
3. Authorization to file insurance claims and receive direct payment for services rendered (next page).

Primary Medical Insurance: _____ Phone #: _____ Employer: _____
Policy Holder Name: _____ Relation to Patient: _____ Policy Holder D.O.B.: _____
Policy Holder Phone: _____ PCP Referral Required: Yes/ No
Policy#: _____ Group#: _____ PCP: _____

Secondary Medical Insurance: _____ Phone #: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy Holder D.O.B.: _____ Employer: _____ PCP Referral Required? Yes No
Policy#: _____ Group#: _____ PCP: _____

Vision Plan: _____ Phone #: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy Holder D.O.B.: _____ Policy Holder Social: _____-___-_____ Employer: _____
Policy #: _____ Group #: _____

ARTHUR A. MEDINA, JR., O.D.

INFORMED CONSENT & TREATMENT AUTHORIZATION

The law requires that we make every effort to inform you of your rights related to your personal health, information.

- I have read or had explained to me the *Notice of Privacy Practices* for Arthur A. Medina, Jr., O.D. and agree to continue my care with Arthur A. Medina, Jr., O.D. under said terms.
- I was given the opportunity but declined to read the *Notice of Privacy Practices,* for Arthur A. Medina Jr., O.D. but wish to continue my care with Arthur A. Medina, Jr., O.D. under the terms of his privacy policies.
- I have read or had explained the *Notice of Privacy Practices* for Arthur A. Medina, Jr., O.D. and do not wish to continue my care with Arthur A. Medina, Jr., O.D. under said terms.
- The *Notice of Privacy Practices* could not be read due to the emergent nature of the care or the reason described as:

  _____

- I (do) _____ (do not) _____ authorize Arthur A. Medina, Jr., O.D. or his staff to leave a message with available persons at my home phone number, on my answering machine, or with the emergency contact listed above.
- I (do) _____ (do not) _____ authorize Arthur A. Medina, Jr., O.D. or his staff to text the phone number provided
- I (do) _____ (do not) _____ authorize Arthur A. Medina, Jr., O.D. or his staff to email the email address provided

I hereby authorize Arthur A. Medina, Jr., O.D. to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. Medina Eye Care is now offering dual services in the optometric & audiology arena. Medina Eye Care is now affiliated with Puretone Hearing Aid Center of San Antonio and will disclose PHI obtained with your consent. I have read & understand the above information & am signing this form voluntarily.

_____ _____

Patient or Legal Guardian's Signature Date

FINANCIAL & INSURANCE FILING POLICY

- *All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay.*
- *If your insurance company does not pay your claim within 30 days, it is your responsibility to contacts them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
- *If your insurance does not cover within 45 days, we will require you to pay the balance by cash, check, money order, or credit card.*
- *Payment for copay and/or deductible is due at the time of services and are rendered.*
- *We accept cash, checks, Visa, Mastercard, American Express, Discover, and Care Credit*
- *Cancelled or rescheduled appointments are subject to a fee if we do not receive a 24-hour cancellation advance notice.*
- *In the event the refraction fee is not covered by your insurance carrier, you will be charged an additional fee to your out of pocket for the office visit.*

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I _____, authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Arthur A. Medina, Jr., O.D. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Arthur A. Medina, Jr., O.D. for any services furnished to me by Arthur A. Medina, Jr., O.D. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents. any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that. payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases. the supplier agrees to accept the charge determination of the Medicare carrier as the full charge. & the patient is responsible only for the deductible, copay, & non-covered services. Copay & deductible are based upon the charge determination of the Medicare carrier: I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent. I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

_____ _____

Patient or Legal Guardian's Signature Date