



Please Print Clearly

Patient Name _____
Male Female Marital Status _____ Date of Birth _____ Age _____
Home Address _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
Home Ph.# _____ Work Ph.# _____ Cell Ph.# _____ SS# _____
Employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Responsible Party _____ Relationship to Patient _____
Employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Work Ph.# _____ Cell Ph.# _____ SS# _____
Emergency Contact _____ Relationship to Patient _____
Emergency Home Ph# _____ Emergency Cell Ph# _____

INSURANCE INFORMATION : Please be sure to show all medical, vision and pharmacy Rx cards to receptionist.

PRIMARY INSURANCE

Name of Subscriber _____ Date of Birth _____ SS# _____
I.D.# _____ Group# _____ Employer _____

SECONDARY INSURANCE

Name of Subscriber _____ Date of Birth _____ SS# _____
I.D.# _____ Group# _____ Employer _____

Are you covered by:

MEDICARE Yes No Name of prescription drug plan _____

MEDICARE SUPPLEMENTAL INSURANCE Yes No Name of plan _____

MEDI-CAL Yes No If yes, please see that our receptionist makes a copy of your Medi-Cal card.

OTHER MEDICAL INSURANCE Yes No If yes, please check with our receptionist.

Prescriptions filled at what pharmacy? _____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE (please put name) _____

I authorize payment of medical benefits to the physician (INITIAL) _____

I authorize the release of any medical information necessary to process any claim (INITIAL) _____

I understand I am financially responsible for all charges. Fees are due and payable on the date services are rendered unless credit arrangements are made in advance, or if your insurance is one with which we are contracted.

Signature

Date

Update _____ Initial _____ Update _____ Initial _____

KINGS EYE CENTER CONSENT AGREEMENT

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND /OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Kings Eye Center originates and maintains records describing my health history, symptoms, examinations, test results, diagnoses, slides, photos, treatment, personal data and any plans for future care or treatment. I understand that this information serves as:

- * a basis for planning my care and treatment
- * a means of communication among the many health professionals who contribute to my care
- * a source of information for applying my diagnosis and surgical information for billing purposes
- * a means by which a third-party payer can verify that services billed were actually provided
- * and a tool for routine healthcare operations such as assessing quality patient care and management by healthcare professionals

I understand and have been offered and/or provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Kings Eye Center reserves the right to change the notice and practices and will notify me of any revised notice. I understand that I have the right to the use of my health information. I also understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Kings Eye Center has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

I further consent to information regarding my healthcare treatment and confidential medical records to be released to the following people:

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

Signature of Patient or Legal Representative Witness

Patients Name (please print) _____

Signature _____

Date: _____

(This consent valid for 6 years from date of signature)



Kings Eye Center Medical Group

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559-582-3645 (FAX)
www.kingseyecenter.com

Theresa P. Poindexter, MD
Bradley A. Beard, MD
Laura L. Howard, MD
Ronald S. Keck, OD

**Please bring your current glasses or contact lenses and
your current medications to this appointment.**

TO OUR PATIENTS:

Refraction is the process of determining the eye's refractive error, or need for corrective spectacles (glasses) and/or contact lenses. It is an essential part of most eye examinations. This service is NOT a benefit covered by Medicare or most other insurance plans. Our office fee for a refraction is \$35.00. This fee* will be collected from our patients in addition to any insurance co-payment.

ACKNOWLEDGEMENT:

I have read the above information and understand the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment is separate from and not included in the refraction fee.

Signature of Patient/Responsible Party

Date

**Payment of refraction fee and insurance co-payment will be due at the time of service.*

IMPORTANT APPOINTMENT INFORMATION

Thank you for scheduling your eye appointment at Kings Eye Center. The following information will help you come prepared to your appointment and minimize your wait time. Please be aware that your eyes may be dilated for this appointment. You may want to bring someone to drive you home. **Please complete all forms included and bring them with you along with your current glasses, contact lenses, and medications. You will also need to present your photo ID and insurance cards when you check in at the front counter.**

It is our policy to charge for missed appointments if we are not notified at least 24 hours in advance. The fee for the first missed appointment can be up to \$50.00. For all subsequent missed appointments we may charge a full exam fee of up to \$185.00. These fees are not covered by your insurance.

Also, please be advised that any patient under 18 years of age is considered a minor child. **A minor child must be accompanied by a parent or legal guardian during any appointment in this office.** If your child's appointment must be rescheduled to meet this requirement you should notify our office at least 24 hours in advance to avoid a missed appointment charge. We will call you to confirm your appointment 1-2 business days prior to your scheduled appointment. Unconfirmed appointments may be cancelled. If you have any questions or concerns, please call our office at 585-3937. We look forward to seeing you soon!