Kings Eye Center
MEDICAL GROUP, INC.
1395 West Lacey Blvd. • Hanford, CA 93230 • Tel: (559) 585-3937
321 C Street • Lemoore, CA 93245 • Tel: (559) 924-2666
www.kingseyecenter.com

Please Print Clearly

Patient Name _____ (First) _____ (Middle Initial) _____ (Last)

Male ❑ Female ❑ Marital Status _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Ph.# _____ Work Ph.# _____ Cell Ph.# _____ SS# _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship to Patient _____

Emergency Home Ph.# _____ Emergency Cell Ph.# _____

Preferred Language _____ Email Address _____

Race (Circle One):	**AND**	**Ethnicity (Circle One):**
Unknown or Decline to State		Unknown or Decline to State
American Indian or Alaska Native		Hispanic or Latino
Asian		Not Hispanic or Latino
Black or African American		
Native Hawaiian or Other Pacific Islander		
White		

Responsible Party _____ Relationship to Patient _____

Employer/Occupation _____ DOB _____ DL# _____

Business Address _____ City _____ State _____ Zip _____

Work Ph.# _____ Cell Ph.# _____ SS# _____

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

Primary Care Physician _____ City _____

Pharmacy _____ Prescription Drug Plan Name _____

PRIMARY INSURANCE

Name of Subscriber _____ Date of Birth _____ SS# _____

Subscriber's relationship to patient _____ Employer _____

SECONDARY INSURANCE

Name of Subscriber _____ Date of Birth _____ SS# _____

Subscriber's relationship to patient _____ Employer _____

➡ I authorize payment of medical benefits by my Insurance Company to the physician. **(INITIAL)** _____

➡ I authorize the release of any of my medical information necessary to process any of my claims. **(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 my insurance is one with which you are contracted. **(INITIAL)** _____

_____ **SIGNATURE** _____ **DATE**

Kings Eye Center Medical Group, Inc.

1395 W. Lacey Blvd. Hanford, CA 93230
Phone 559.585.3937 Fax 559.582.3645

321 C Street Lemoore, CA 93245
Phone 559.924.2666 Fax 559.924.0266

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 **$45.00**. 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.*

5/18/2017

KINGS EYE CENTER EL ACUERDO DE CONSENTIMIENTO

KINGS EYE CENTER CONSENT AGREEMENT

CONSENT TO THE USE AND DISCLOSURE OF HEALTHCARE 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, examination, test results, diagnoses, photos, treatment, personal data and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my eye care and treatment
- a means of communication among the many healthcare professionals who contribute to my eye 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 and 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 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

Patient's Name (please print) _____

Signature_____

Date_____

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

*To be signed by all adult patients or legal representative and kept in patient's chart.

*El Acuerdo de Consentimiento debe ser firmado por todos los pacientes adultos o representante legal y se mantendrá en el expediente del paciente.