Kings Eye Center Medical Group, Inc.
1395 W. Lacey Blvd. • Hanford, CA 93230 • Phone (559) 585-3937 • Toll Free (800)675-8088 • Fax (559)582-3645
www.kingseyecenter.com

Patient Name _____ _____
First Initial Last Nickname

Date of Birth ___/___/___ Mailing Address _____

Male □ Female □ City_____ State_____ Zip Code_____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Social Security Number **please give to the receptionist** Married □ Single □ Other □ _____

Email Address_____ Preferred Language _____

Employer _____ (_____)_____-_____
Name Address Phone Number

Emergency Contact _____ Relationship to Patient _____

Emergency Home Phone (_____)_____ Emergency Cell Phone (_____)_____

Primary Care Physician _____ Phone Number (_____)_____-_____

Preferred Pharmacy _____ City/Location_____

PLEASE PRESENT ALL MEDICAL, VISION, AND PRESCRIPTION INSURANCE CARDS ALONG WITH YOUR PHOTO ID.

Primary Insurance Subscriber _____ Relationship to Patient_____

Date of Birth ____/____/____ Social Security Number _____-_____-_____ Drivers License Number _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Mailing Address (if different from above) _____

City_____ State_____ Zip Code _____

Employer _____ (_____)_____-_____
Name Address Phone Number

Secondary Insurance Subscriber _____ Relationship to Patient_____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Date of Birth ____/____/____ Social Security Number _____-_____-_____ Drivers License Number _____

Mailing Address (if different from above) _____

City_____ State_____ Zip Code _____

Employer _____ (_____)_____-_____
Name Address Phone Number

I authorize payment of my medical/vision benefits by my insurance company to the provider..... **(INITIALS)** _____
I authorize the release of any medical/vision information necessary to process any of my claims..... **(INITIALS)** _____
I recognize that I am financially responsible for all charges incurred at Kings Eye Center. All costs must be paid the day services are rendered, unless arranged in advance, or if my insurance is one with which Kings Eye Center is contracted and rendered services are a covered benefit of my insurance plan ..... **(INITIALS)** _____

_____ _____/_____/_____
Responsible Party Signature **Date**

Bradley A. Beard, MD **Ronald S. Keck, OD** **Stacy R. Omon, OD** **Nathan Panttaja, OD**

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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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

_____

☐ I do not wish to have my information released to anyone.

Patient Name (please print) _____

Signature _____ Date _____

Signature of Patient or Legal Representative Witness*

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

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

01/14/2020

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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 glasses and/or contact lenses. It is an essential part of most eye examinations. This service is ***NOT*** a benefit covered by Medicare and we are not contracted with Medi-cal. Most other medical insurance plans do not cover this either. If you have a vision plan, please be sure to give this information to the receptionist.

Our office fee for a refraction is **$80.00**. This fee will be due and payable at the time of the visit, **in addition** to any insurance co-payment and/or share of cost amount.

ACKNOWLEDGEMENT:

I have read the above information and understand the refraction is not covered by Medicare or Medi-cal, and most other medical insurance plans. I accept full financial responsibility for the cost of this service. The co-payment and/or share of cost amount is separate from and not included in the refraction fee.

_____ _____

Signature of Patient/Responsible Party Date

*This form shall remain in effect unless/until revoked in writing.

08/30/2024

NOTICE OF
OPEN PAYMENTS DATABASE

Effective Date: January 1, 2023

THIS NOTICE DESCRIBES THE OPEN PAYMENTS DISCLOSURE PROGRAM THAT PROMOTES TRANSPARENCY AND ACCOUNTABILITY BY HELPING CONSUMERS UNDERSTAND THE FINANCIAL RELATIONSHIPS BETWEEN PHARMACEUTICAL, MEDICAL DEVICE INDUSTRIES, PHYSICIANS, AND TEACHING HOSPITALS.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

The Open Payments database is at the following link: https://openpaymentsdata.cms.gov

Patient Name (please print) _____

Signature _____ **Date** _____

Signature of Patient or Legal Representative Witness*

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

2/9/2023

KINGS EYE CENTER MEDICAL GROUP, INC
MEDICATION LIST

Patient Name_____DOB_____
Primary Care Physician_____

Please provide us with a list of all prescription and nonprescription medications you are currently taking.

Medication name	Dose (mg, tsp, etc.)	How often do you take it?

Allergies to Medications:

Medication Name	Type of Reaction (rash, breathing difficulties, etc.)

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