Patient Profile

Doctor: _____

Appointment Doctor: Brame MD, Cory Lynne

PATIENT INFORMATION

Name: _____

Address: _____

_____

City,State, Zip: _____

Phone: _____ [ ]Home [ ]Work [ ]Other

Phone: _____ [ ]Home [ ]Work [ ]Other

Patient ID #: _____ Sex: [ ]M [ ]F

Date of Birth: _____

Social Security #: _____

Marital Status: [ ]Married [ ]Single [ ]Divorced

Patient e-mail address: _____

Language: _____

Race: _____ Ethnicity: _____

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [X]Other

Phone: _____

Employer: _____

EMERGENCY CONTACTS

_____

_____

_____

RESPONSIBLE PARTY

[ ]Same as Patient

Name: _____

Address: _____

_____

City,State: _____

RESPONSIBLE PARTY EMPLOYER

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Name of Insured: _____

Insured Phone: _____

Name of Insurance Co: _____

Relationship to Primary Insured/Guarantor: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Name of Insured: _____

Insured Phone: _____

Name of Insurance Co: _____

Appt Date & Time _____

Relationship to Primary Insured/Guarantor: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

CONSENT TO TREAT: I authorize the provider responsible for care of the above named patient to provide diagnosis and treatment of services.

FINANCIAL RESPONSIBILITY: I agree to be personally responsible and fully responsible for payment for services rendered in accordance with any insurance benefits where applicable. I understand that I am financially responsible for charges not covered by my plan or for claims denied because of my failure to comply with conditions set by my insurance carrier. These conditions may include but are not limited to: failure to make co-payment or obtain a written referral for services provided by someone other than my primary care physician. A finance charge of 1½% per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

ASSIGNMENT OF BENEFITS: I request insurance benefits for services provided by paid directly to the medical clinic. I verify the accuracy of the above listed demographic and insurance information and I authorize the release of any medical information necessary to process payment for services provided.

Signature _____ Date _____

COAST OPHTHALMOLOGY

The goal of this office is to provide you with the best medical care available. A clear understanding of our financial arrangements is essential for a successful doctor/ patient relationship.

____ INITIAL

TO ALL PATIENTS

Refraction is an important part of today's exam which determines your best possible visual acuity. Refraction is also to evaluate your present glasses and prescribe new corrective lenses. Without refraction, the doctor is not able to fully assess the health and function of your eyes. Medicare and most insurance plans do not cover refractions as it is not considered a medical test. If you have separate vision insurance, a copy of the bill will be provided at your request to be submitted by you for reimbursement. The office fee for basic refraction is $55 and with prism ranges from $75 to $90. This is collected at the time of service, otherwise a $10 billing fee will be applied to your account.

____ INITIAL

CONTACT LENS PATIENTS

A new contact lens fitting or a contact lens prescription is a professional fee in addition to your refraction or exam. This fee will range from $50 to $125. This fee is collected at the time of service, otherwise a $10 billing fee will be added. Fee includes contact lens fitting follow-up visits.

____ INITIAL

INSURANCE PATIENTS

This office does not accept any HMO insurance plans. If you have an HMO, then you personally will be responsible for any exams or procedures out of pocket.

Your insurance is an agreement between you and your insurance company. It is recommended that you contact your insurance company regarding your benefits and coverage. It is your responsibility to be aware of any limitations such as pre-existing clauses, second opinion requirements, etc. written in your policy.

If you wish us to bill your insurance, you must have all up-to-date insurance information with you at the time service is rendered. Otherwise we accept cash, credit cards, or checks for payment, or we will be happy to reschedule your appointment.

Charges for your treatment will be billed to your insurance company. However, if your insurance company has not paid their portion of the charges within 90 days, the account will revert to your responsibility.

____ INITIAL

CO-PAYMENTS

All Co-payment amounts are due at the time of service. This amount is written on your insurance card. If not collected at time of service, a $10 billing fee will be applied to your account.

____ INITIAL

SECONDARY INSURANCE PATIENTS

Our billing company, Financial Data Management (FDM), will bill both Medicare as well as your secondary insurance for your visit today. As FDM automatically bills monthly, please disregard only the first statement you receive, as your secondary insurance may not have had enough time to process your claim. Any subsequent billing should be paid in full.

____ INITIAL

TO ALL PATIENTS- RIDE AGREEMENT

In order to perform a thorough eye exam, the pupils must be dilated. This can cause a temporary increase in glare and blurred vision. If you experience glare or blurred vision following the exam, it may be unsafe for you to drive. If this occurs, it is recommended that you arrange for other transportation so that you are not operating a motor vehicle unsafely.

My signature below indicates that I have read and understand the above statements. I have received a copy of this agreement for my records.

Print Name _____

Signed _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Coast Ophthalmology
360 San Miguel Drive
Suite 307
Newport Beach, CA 92660

Soo Farley, COT
Privacy Officer
949- 721-0800

I hereby acknowledge that I received a copy of this medical practice's NOTICE OF PRIVACY PRACTICES. I further acknowledge that a copy of the current notice will be available at the reception area, and that I will be offered a copy of any future amended Notice of Privacy Practices.

Signed _____ Date _____

Print Name _____ Phone _____

If not signed by the patient, please indicate:

Relationship:

__ parent or guardian of minor patient

__ guardian or conservator of an incompetent patient

__ beneficiary or personal representative of deceased patient

Name of the Patient _____