



Type of Visit: Routine Medical Contact Lens Wearer? Yes No

PATIENT INFORMATION

Name (Last, First, Middle Initial)		Date of Birth	Social Security #	
Local Address		Home Phone	Medical Record #	Sex
City, State, Zip		Secondary/Billing Address (If Applicable)		
Work Phone	Cell Phone	City, State, Zip		
E-Mail Address		Primary Employer		
Primary Care Physician		Local Address		
Referring Physician		City, State, Zip		

RESPONSIBLE PARTY INFORMATION (if different than above)

Name (Last, First, Middle Initial)		Social Security #	Date of Birth	Sex
Local Address		Name of Nearest Friend or Relative That Does Not Live with Patient		
City, State, Zip		Local Address		
Home Phone		City, State, Zip		
Relationship to Patient		Home Phone		

PRIMARY INSURANCE

Name of Insurance Company		Policy # / ID #		
Name of Insured		Group #		
Address of Insurance Company		Co-Pay Amount		
City, State, Zip		Insured Social Security #	Insured Date of Birth	
Relationship to Patient		Effective Date	Expiration Date	

SECONDARY INSURANCE

Name of Insurance Company		Policy # / ID #		
Name of Insured		Group #		
Address of Insurance Company		Co-Pay Amount		
City, State, Zip		Insured Social Security #	Insured Date of Birth	
Relationship to Patient		Effective Date	Expiration Date	

SIGNATURE OF PATIENT / GUARDIAN _____

DATE _____

IS THIS A WORK RELATED INJURY? _____ Yes _____ No

If you answered yes, please notify the receptionist immediately.

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____

MEDICATIONS: Please list all medications you are currently taking and include dosages.

ALLERGIES: Please list.

The following authorization permits us to provide appropriate information to your insurance company, Medicare, other physicians, and others who are legally entitled. Please read carefully.

LIFETIME AUTHORIZATION

I authorize reports of my evaluations, treatments and any follow-up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers that I have or will identify to you. I also authorize release of all pertinent medical information to any hospital or outpatient facility or clinic. Photography may be used in the evaluation and management of my condition. I consent to the taking of such photographs, if necessary, and to their possible use in medical meetings, books, journals or other aspects of medical education. If provided, I authorize the use of E-mail as a means of contact.

I UNDERSTAND THAT I AM FULLY AND LEGALLY RESPONSIBLE FOR PAYMENT OF THE ACCOUNT WHICH INCLUDES ALL OUTSTANDING BALANCES NOT COVERED BY MEDICARE AND/OR INSURANCE COMPANIES.

(I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies indicated, or to my employer if this is a worker's compensation claim, any information, including retirement dates, needed for this or a related insurance or Medicare claim.) I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to a party who accepts assignment.

Patient's Name (Please Print)

Patient's Signature

Date



Financial Policy

Thank you for selecting Sabates Eye Centers (SEC) for your eye care. We are committed to providing the best eye care possible. The following information outlines financial responsibilities related to payment for your professional services.

You, the patient, are ultimately responsible for all charges associated with your care. Sabates Eye Centers participates with a variety of insurance plans. We refer to "in network" as the insurance companies that we have a contract agreement with. Please be aware, you incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check your insurance company for coverage and participation detail.

We will submit insurance claims on your behalf to your primary insurance and one secondary insurance carrier. However, it is important to remember that your insurance is a contract between you and your insurer and it is your responsibility to know and understand the requirements of your insurance plan. We will not be responsible if you do not follow the specific terms of your insurance agreement and if we do not receive payment from them, you will be responsible.

It is your responsibility to:

- Bring your insurance card and picture ID to every visit.
- Be prepared to pay for your co-pay and non-covered services at each visit.
- Obtain any referrals that your insurance requires.
- Provide a valid physical address. Post office boxes may be used as mailing addresses only.

Failure to provide any of the above may require you to pay in full or reschedule your visit.

If there is a remaining balance due after your insurance carrier pays, you will be billed. If that balance is not paid within 60 days, we send outstanding balances to an outside collection agency without further notice. Payment arrangements can be made, but it is your responsibility to contact the Billing Office before it is turned over to an outside agency. The Billing Office can be reached at (913) 261-2080, option 2.

We accept cash, check, VISA, MasterCard, Discover and American Express.

If the patient is a minor (17 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, required referrals, insurance and picture ID cards.

Our office will do what we can to assist you. If you have any questions or concerns, please do not hesitate to contact our Billing Office at (913) 261-2080, option 2; or Toll Free at (800) 742-0020, Monday through Friday, 8:00 am to 5:00 pm.

Sabates Eye Centers believes that a good physician/patient relationship is based on understanding and communication. Your signature below indicates that you have read and agree to this Financial Policy.

Patient or Guardian's Signature

Date

In an effort to be of service to you, we have listed below websites for information regarding financing options for healthcare services incurred. We do not endorse any of these financing options.

www.creditcare.com

www.chasehealthadvance.com



Personal Representative Designation Form

Patient Name: _____ Our MR#: _____

This form allows you to give Sabates Eye Centers permission to discuss your Protected Health Information with a person(s) you appoint as your Personal Representative.

You are not required to name a Personal Representative, but if you do not, we will not disclose your Protected Health Information to someone who may call on your behalf. Your Personal Representative may be anyone of your choosing such as a spouse, parent, child or friend. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

You may revoke this designation of a Personal Representative at any time by giving written notice to the Privacy Official (see reverse side for mailing address).

*** I **decline** to name a Personal Representative. Please check box, sign and date this form.

1.) Personal Representative

To Confirm Personal Representative

Full Name: _____

Date of Birth: _____

Relationship to Patient: _____

Home Phone: _____

Alternative Phone: _____

Any limitations on issues your personal representative may discuss: Yes No
If yes, please specify (example: Medical, financial, etc.):

2.) Personal Representative

To Confirm Personal Representative

Full Name: _____

Date of Birth: _____

Relationship to Patient: _____

Home Phone: _____

Alternative Phone: _____

Any limitations on issues your personal representative may discuss: Yes No
If yes, please specify (example: Medical, financial, etc.):

3.) Personal Representative

To Confirm Personal Representative

Full Name: _____

Date of Birth: _____

Relationship to Patient: _____

Home Phone: _____

Alternative Phone: _____

Any limitations on issues your personal representative may discuss: Yes No
If yes, please specify (example: Medical, financial, etc.):

4.) Personal Representative

To Confirm Personal Representative

Full Name: _____

Date of Birth: _____

Relationship to Patient: _____

Home Phone: _____

Alternative Phone: _____

Any limitations on issues your personal representative may discuss: If yes, please specify (example: Medical, financial, etc.):	Yes	No
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5.) Personal Representative

To Confirm Personal Representative

Full Name: _____

Date of Birth: _____

Relationship to Patient: _____

Home Phone: _____

Alternative Phone: _____

Any limitations on issues your personal representative may discuss: If yes, please specify (example: Medical, financial, etc.):	Yes	No
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6.) Personal Representative

To Confirm Personal Representative

Full Name: _____

Date of Birth: _____

Relationship to Patient: _____

Home Phone: _____

Alternative Phone: _____

Any limitations on issues your personal representative may discuss: If yes, please specify (example: Medical, financial, etc.):	Yes	No
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Printed Patient Name: _____

Date of Birth: _____

Signed Patient/Legal:
Representative _____

Date: _____

SEC Witness Signature Date

Please return this completed form to:
Sabates Eye Centers
Privacy Official
3500 West 75th St., Suite 100
Prairie Village, KS 66208

If you have any questions about this Personal Representative Designation form, please call the Privacy Official at (913) 261-2020.