



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**



At Sabates Eye Centers we are dedicated to providing the best eye care to you and your family. As part of this goal, we are focused on meeting Meaningful Use objectives to improve clinical quality and patient outcomes. "Meaningful Use" is a government program to ensure that healthcare professionals are utilizing their Electronic Medical Record (EMR) system efficiently to improve healthcare quality and patient safety.

A core objective in Meaningful Use is to document patient demographics including: "preferred language", "gender", "race", "ethnicity", and "date of birth". The Race, Language and Ethnicity categories below are defined by the Federal Office of Management and Budget and the United States Census Bureau.

Please use the lists below when indicating your Race, Language and Ethnicity:

### **RACE**

<input type="checkbox"/> - American Indian or Alaska Native	<input type="checkbox"/> - Native Hawaiian or Pacific Islander
<input type="checkbox"/> - Asian	<input type="checkbox"/> - White/Caucasian
<input type="checkbox"/> - Black or African American	<input type="checkbox"/> - Other

### **PREFERRED LANGUAGE**

<input type="checkbox"/> - English	<input type="checkbox"/> - Spanish	<input type="checkbox"/> - Other
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### **ETHNICITY**

<input type="checkbox"/> - Non-Hispanic or Latino ethnicity	<input type="checkbox"/> - Hispanic or Latino ethnicity
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Participation in this questionnaire is voluntary, you are not obligated to provide this information if you do not wish.

- I do not wish to participate

Sabates Eye Centers understands that this is personal and sensitive information. We want to assure you that this information will only be used as part of the Meaningful Use objectives.

Patient Initials: \_\_\_\_\_



## 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](http://www.creditcare.com)

[www.chasehealthadvance.com](http://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.

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

### 1.) Personal Representative

### To Confirm Personal Representative

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

### To Confirm Personal Representative

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

### To Confirm Personal Representative

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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: \_\_\_\_\_ Date: \_\_\_\_\_

Signed Patient/Legal Representative: \_\_\_\_\_ SEC Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return this completed form to: Sabates Eye Centers Privacy Official 11261 Nall Ave. Leawood, KS 66211**

**If you have any questions about this Personal Representative Designation form, please call the Privacy Official at (913) 261-2020.** Updated: March 2010