



EAST-WEST EYE INSTITUTE

PATIENT INFORMATION SHEET AND AGREEMENT

E-Mail : _____

BEST CONTACT PHONE # (_____) _____ **CELL PHONE #** (_____) _____

CELL PHONE CARRIER: [AT&T | Verizon | T-Mobile | Sprint | Other(specify): _____]

PATIENT NAME : _____ { } MALE { } FEMALE

ADDRESS : _____ **CITY :** _____

STATE : ____ **ZIPCODE :** _____ **HOME PHONE #** (_____) _____ **DRIV. LIC. #** _____

DATE OF BIRTH : ____ / ____ / ____ **SOCIAL SECURITY #** _____ - _____ - _____

MARITAL STATUS : { } SINGLE { } MARRIED { } DIVORCED { } WIDOWED

REFERRED BY : _____ **PHONE #** (_____) _____

[Yelp | Doctor | Friend | Internet | Other(specify): _____]

ADDRESS : _____ **CITY :** _____ **STATE :** ____ **ZIP :** _____

PERSON TO CONTACT IN CASE OF EMERGENCY OR IF OFFICE CANNOT CONTACT PATIENT DIRECTLY

NAME : _____ **RELATIONSHIP :** _____ **PHONE #** (_____) _____

BILLING INFORMATION

EMPLOYER : _____ **PHONE #** (_____) _____ **EXT :** _____

EMP. ADDRESS : _____ **CITY :** _____ **STATE :** ____ **ZIP :** _____

INSURANCE INFORMATION: (PLEASE LIST IF INSURANCE CARD IS NOT TAKEN BY RECEPTIONIST)

PRIVATE INS. CO. : _____ **MEDICARE#** _____

ADDRESS : _____ **CITY :** _____ **STATE :** ____ **ZIP :** _____

INSURED'S NAME : _____ **RELATIONSHIP TO PATIENT :** _____

INSURED'S CERTIFICATE/SUBSCRIBER # _____ **GROUP #** _____

RESPONSIBLE PARTY: (IF PATIENT IS A MINOR OR IF SOMEONE ELSE ASSUMES RESPONSIBILITY)

RESPONSIBLE PARTY : _____ **RELATIONSHIP :** _____

ADDRESS : _____ **CITY :** _____ **STATE :** ____ **ZIP :** _____

It is the policy of East-West Eye Institute (EWEI) to require payment in full at the time the services are provided. By signing below, I am authorizing EWEI and its physicians to furnish the above insurance companies all necessary information they may require. If my insurance is billed by EWEI, I assign to EWEI all payments for medical services rendered. With regard to medical assignment, I certify that the above information given by me in applying for payment under title XVIII of the Social Security Act is true and correct. I request that payment of authorized benefits be made on my behalf.

I understand that:

- 1) Eye drops will be instilled into my eyes unless I withhold permission for their use.
- 2) Any adverse reaction from the eye drops are not the responsibility of EWEI.
- 3) If my eyes are dilated for an examination, there may be blurriness and glare resulting in poor vision lasting 3–48 hours. I should refrain from driving during this time.

I understand that I am responsible for payment for medical care provided and that any sums received from my insurance carrier or Medicare will be used to reduce the amount for which I am responsible. I also certify that EWEI is not responsible for any misunderstandings of patient's insurance on the part of the patient and that it is not the duty of EWEI to explain patient's insurance to the patient. I agree that I am responsible for payment for the following but not limited to:

- 1) Services not covered by Medicare and/or insurance.
- 2) Annual deductible of any insurance company including Medicare.
- 3) Coinsurance payments required by my insurance.
- 4) Refractions (eye examinations for glasses prescriptions), which are not covered by most insurance carriers.
- 5) Any documents and forms which require information to be filled out and signed by physician(s) including, but not limited to, DMV forms, disability forms, FSA forms, etc.
- 6) Separate medical counseling for patients, family, guardians, etc.
- 7) Telephone conversations with physicians, family members, medical personnel, legal counsel and the like regarding medical matters relative to my treatment.
- 8) Written correspondence to physicians, family members, legal counsel, insurance agencies and the like regarding medical matters relative to my treatment.

9) For appointments that are not cancelled at least 48 hours prior to your scheduled date/time, there will be a \$50.00 cancellation fee.

- 10) Finance charges equal to 1.5%, or highest allowed by law, per month of balances not paid within 90 days from the date billed and for reasonable attorneys fee in the event that it is necessary to file suit to collect the balance due.
- 11) Cosmetic surgery and procedures.
- 12) Services for which authorization is required from primary care physician, but has not been received.

I have read, understood, and agree to the above terms and warrant that the information provided is true and correct.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322, www.mbc.ca.gov.

Signature of patient or legal guardian

Date _____

Signature of insured or person responsible for payment (if different from above)