EAST-WEST EYE INSTITUTE

PATIENT INFORMATION SHEET AND AGREEMENT

PATIENT NAME/NICKNAME : _____

E-MAIL : _____

CONTACT PREFERENCE: { } HOME { } WORK { } CELL { } E-MAIL { } TEXT { } MAIL

HOME PHONE # (_____)_____ WORK PHONE # (_____)_____EXT_____

CELL PHONE # (_____)_____ CELL PHONE CARRIER: _____

GENDER: { } MALE { } FEMALE ADDRESS TYPE: { } HOME { } WORK { } BILLING

ADDRESS : _____ CITY : _____

STATE : _____ ZIP CODE : _____ SOCIAL SECURITY # _____ -_____ -_____

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

DATE OF BIRTH:_____ /_____ / _____ **STATE/COUNTRY OF BIRTH** : _____

PRIMARY LANGUAGE : _____ **MOTHER'S MAIDEN NAME** : _____

RACE : { } AMERICAN INDIAN/ALASKA NATIVE { } ASIAN
{ } BLACK/AFRICAN AMERICAN { } NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
{ } WHITE { } PATIENT DECLINED TO SPECIFY

ETHNICITY : { } NOT HISPANIC OR LATINO { } HISPANIC OR LATINO
{ } PATIENT DECLINED TO SPECIFY

REFERRED BY : _____ PHONE # (_____)_____
[Yelp | Doctor | Friend | Internet | Other (specify)]

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

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON OR IF OFFICE IS UNABLE TO CONTACT PATIENT DIRECTLY

NAME : _____ PHONE # (____)_____

RELATIONSHIP : _____ GENDER: { } MALE { } FEMALE

BILLING/RESPONSIBLE INFORMATION

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 : _____

SOCIAL SECURITY # _____ -____ -_____ DATE OF BIRTH : __ /___ /___ PHONE #(____)_____

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 RENDERED. 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 ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO EWEI. 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 OR GLARE RESULTING IN DECREASE OF VISION LASTING ANYWHERE FROM 3 TO 48 HOURS. IF UNCOMFORTABLE, 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. FURTHERMORE, IT IS NOT THE RESPONSIBILITY OF EWEI TO EXPLAIN THE PATIENT'S INSURANCE TO THE PATIENT OR ANY MISUNDERSTANDING BETWEEN THE PATIENT AND THE PATIENT'S INSURANCE COMPANY.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF THE FOLLOWING, BUT NOT LIMITED TO:

1. SERVICES NOT COVERED BY MEDICARE, SECONDARY INSURANCE, PRIVATE INSURANCE, HMO, OVERSEAS INSURANCE AND/OR ANY OTHER TYPE OF INSURANCE PRESENTED TO EWEI.
2. ANNUAL DEDUCTIBLE OF ANY INSURANCE COMPANY INCLUDING MEDICARE.
3. COINSURANCE PAYMENTS REQUIRED BY MY INSURANCE (INCLUDING MEDICARE)
4. REFRACTIONS (EYE EXAMINATIONS FOR GLASSES PRESCRIPTIONS), WHICH ARE NOT COVERED BY MOST INSURANCE CARRIERS.
5. SEPARATE MEDICAL COUNSELING FOR PATIENTS, FAMILY, GUARDIANS, ETC.
6. TELEPHONE CONVERSATIONS WITH PHYSICIANS, FAMILY MEMBERS, MEDICAL PERSONNEL, LEGAL COUNSEL AND THE LIKE REGARDING MEDICAL MATTERS RELATIVE TO MY TREATMENT.
7. WRITTEN CORRESPONDENCE TO PHYSICIANS, FAMILY MEMBERS, LEGAL COUNSEL, INSURANCE AGENCIES AND THE LIKE REGARDING MEDICAL MATTERS RELATIVE TO MY TREATMENT.
8. **IF YOU DO NOT SHOW FOR YOUR SCHEDULED APPOINTMENT OR DO NOT CANCEL YOUR APPOINTMENT 48 HOURS IN ADVANCE A $50.00 FEE WILL BE BILLED TO YOUR ACCOUNT THAT IS NOT COVERED BY YOUR INSURANCE.**
9. 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 ATTORNEY'S FEE IN THE EVENT THAT IT IS NECESSARY TO FILE SUIT TO COLLECT THE BALANCE DUE.
10. COSMETIC PROCEDURES AND SURGERY.
11. OFFICE PROCEDURES, OFFICE EXAMS, TESTING, AND LASERS.
12. PATHOLOGY AND LAB FEES
13. GLASSES, LENSES, CONTACT LENSES, AND ALL OTHER VISUAL AIDES.

I certify that the given insurance card shown is true, correct, and valid today. I understand that my primary carrier will be billed once. I am fully liable for any and all charges incurred, regardless of any third party agreements. I understand the physicians and staff may recommend services that are not covered or partially covered by my insurance. In these cases, I agree that I will pay in full for these services at the time they are provided and understand that East West Eye Institute may not bill my insurance carrier for these services. This agreement supersedes and replaces any and all existing or future agreements made for the provision of health care services by the professional staff of East West Eye Institute and any third party payer.

I HAVE READ, UNDERSTAND, 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.

_____ DATE _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____

SIGNATURE OF INSURED OR PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)