Welcome to Levin Eye Care Center, P.C.

Referral Information Request

Please complete this information before all other forms

Name: _____ Exam Date:_____

E-mail address for newsletter and promotional announcements:

_____

How were you referred to our office?

□VSP Insurance

□Insurance (name):

□Family or friend (name): _____

□Another doctor (name): _____

□Telephone book

□Newspaper article or advertisement

□Internet

□Knew about the office

□Other (please explain): _____

□ Previous Patient – Several years ago

Please have your medical and vision insurance cards available.

Patient Information

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ Social Security # _____
First MI Last

Address _____ City _____ State _____ Zip _____

Birth date _____ Home phone # _____ Work Phone # _____

Email Address _____

Are you: Minor Married Divorced Single Widow/Widower

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone # _____

If you are a student, name of school/college _____

Address _____ City _____ State _____ Zip _____

Teacher's Name _____ School Phone # _____

How did you hear about us? Family Friend Yellow pages Newspaper Other: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Address City State Zip _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

Insurance Information

ROUTINE VISION

Insurance Co. _____

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____

List additional family members and age insured with this insurance _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

MAJOR MEDICAL

Insurance Co. _____

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____

List additional family members and age insured with this insurance _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE

DO YOU HAVE ADDITIONAL INSURANCE? Yes No IF YES, PLEASE COMPLETE THE FOLLOWING:

Insurance Co. _____

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Are you eligible for MEDICARE? Yes No ID # _____

Health History

Name _____ Age _____ Date_____
Reason for today's exam _____
_____
Date of last eye exam _____ Name of eye doctor _____
Date of last medical exam_____ Name of medical doctor _____
Do you or anyone in your immediate family have a history of the following?
List related family member with these conditions: _____
_____

Diabetes	Blindness	High blood pressure
Cataracts	Thyroid	Turned or lazy eye
Glaucoma	Heart condition	

Please check any of the following conditions that apply to you:

Frequent headaches	Pregnant
Allergies	Sinus trouble

Please list all medications you are currently taking: _____
_____
Are you allergic to any medications? If yes, please list: _____

Have you ever had any of the following conditions involving your eyes?

Eye surgery	Flashes of light	Eye infection or disease
Eye injury	Floaters or spots	Double vision
Medical treatment	Poor distance vision	Eye strain
Severe pain	Poor near vision	Eyes burn, itch, or water

Do you currently wear glasses or contacts? Yes No

Do you currently wear sunglasses? Yes No

When do you wear your glasses and sunglasses or contacts?

All the time	Reading/near work
Work safety	Distance tasks only
Computer work	Other, please explain: _____

Are you interested in wearing contact lenses? Yes No
If so, what style?

Soft	Extended Wear	Gas Permeable	Bifocal
Color	Astigmatic	Disposable	Unsure

Do you work at a computer or video display terminal? Yes No
If so, how many hours a day? _____

What hobbies or sports do you participate in? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge The above questions have been accurately answered I understand that providing incorrect information can be dangerous to my health I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me I understand that my eye care insurance carrier may pay less than the actual bill for services I agree to be responsible for payment of all fees rendered on my behalf or my dependents at time of service All fees not paid within 60 days will be transferred to an outside collection agency and a transfer fee of $25 00 will be applied to all transferred accounts

X _____

Steven A. Levin, O.D., F.C.O.V.D.
National Optometrist Of The Year 2002

LEVIN EYE CARE CENTER P.C.
Corrective & Preventative Optometry

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Financial Responsibility and Assignment of Insurance Benefits

I understand and hereby authorize the Levin Eye Care Center, P.C. Healthcare Provider to utilize and to provide information about me necessary to verify, substantiate, and process any insurance claims that I have indicated.

I hereby authorize any insurance carrier, which I have indicated and with which I have any effective policy, to pay directly to Levin Eye Care Center, P.C. the benefits which would otherwise be payable to me. I hereby transfer and assign the payment of benefits from the indicated policy (ies) of insurance to those healthcare providers and/or Levin Eye Care Center, P.C. who have rendered services to me and who accept such benefit assignment. Furthermore, I assign any unpaid charges of the physicians or Levin Eye Care Center, P.C. authorized to bill in connection with its services or to submit a claim to Medicare for payment.

Additionally, I agree to pay all charges and account balances that are not paid in full by the assigned insurance company and that are deemed my responsibility. I understand that payment is immediately due upon services rendered. I am financially responsible for any and all charges incurred while under the care of said physician after 60 days if payment has not been received from my insurance company. I give Levin Eye Care Center, P.C. authorization to apply the outstanding balance to my credit card. If amounts due to the healthcare providers are not paid after reasonable notice and provider efforts to collect, then the account will be considered delinquent- additional service charges may be added to the account balance at that time to offset additional incurred provider billing expense.

In consideration of the services provided to the patient/customer, I/we hereby guarantee payment in full of the patient /customers account in accordance with the financial arrangements made at the time of service/purchase. In event of default in payment, even if no such arrangements were made, reasonable collection agency fees equal to thirty percent (30%) of the delinquent balance and reasonable attorney fees shall be added to the amount due on the account plus any applicable court costs.

By providing my cell phone number, I give prior express consent to receive calls and text messages from the creditor or its third party debt collector at that number, including calls and messages made by an auto dialer or prerecorded message.

_____

Patient's Signature Date

_____

Patient's Personal Representative's Signature Date

_____

Witness Signature Date