

PATIENT UPDATE INFORMATION

Date: _____ Last Visit: _____

Last Name: _____ First Name: _____ DOB: _____

Has your contact information changed since your last visit? YES NO

New Address: _____

New Phone Number: Cell (____) _____ Home: (____) _____ Work: (____) _____

Has your insurance changed since your last visit? YES NO (Please present new card to Front Desk Staff)

New Medical Insurance:

Primary Health Insurance Name: _____ ID #: _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

Secondary Health Insurance Name: _____ ID #: _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

New Vision Insurance:

Vision Insurance Name: _____ ID #: _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

HIPAA PRIVACY RULE

The HIPAA (Health Insurance Portability and Accountability ACT) notification describes in detail how your medical information may be used and disclosed. It also describes how you can access the information. I have been offered a copy of North County Laser Eye Associates HIPAA Notice of Privacy Practices.

REFRACTION POLICY

Insurance companies will only pay for services that it determines to be "Medically Reasonable and Necessary." Refractions (examinations used to determine the prescription of your contacts and glasses) are most often deemed to be non-medical, and therefore are not covered by your health insurance. The cost of the exam is \$45, and I understand that I will be held personally responsible for the payment.

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow a better view of the inside of your eye. These drops blur vision for a length of time and cause light sensitivity. I understand that my vision will be altered and I should use caution while driving or otherwise arrange for transportation. I hereby authorize North County Laser Eye Associates to administer dilating drops.

PATIENT BALANCE RESPONSIBILITY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account and for any professional or diagnostic services rendered as well as any glasses or contacts ordered. I authorize payment of medical benefits payable to the physician. A copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes in any of the information provided on the patient information sheet. I understand that there will be a \$25 late fee for any unpaid balance on my account after 60 days. I understand that my account will be sent to collections after 90 days. I also authorize this office to release my spectacle or contact lens prescription at my request.

Patient Signature: _____ **Date:** _____