EYE MEDICAL CENTER
Medical Excellence Since 1946

7777 Hennessy Blvd.,
Suite 3000, Suite 3001, Suite 4000
Baton Rouge, LA 70808

5000 O'Donovan Blvd., Suite 407
Walker, LA 70785

1615 S. W. Railroad Avenue
Hammond, LA 70403

7539 Corporate Blvd., Suite 100
Baton Rouge, LA 70809

11424 Sullivan Road, Bldg. A, Suite A
Central, LA 70818

Account No. ________________

Date ________________

Scheduled appointment with: (Check one) ☐ Haik, M.D. ☐ Pearce, M.D. ☐ S. Luckett, M.D.
☐ Heigle, M.D. ☐ Fargason, M.D. ☐ Ehrlich, M.D. ☐ Collins, M.D. ☐ Fivgas, M.D. ☐ Rhodes, M.D. ☐ Nelson, M.D.
☐ Abbott, O.D. ☐ Patin, O.D. ☐ Hatcher, M.D. ☐ Tran, M.D. ☐ Dodson, M.D. ☐ Dardar, O.D. ☐ JP Luckett, M.D.

Have you or any member of your household been treated by our physicians before? ☐ Yes ☐ No
If yes, please give name and relationship ________________

PLEASE PRINT

Patient Information

Name ________________ Home Phone ________________
First *M.I.* *Last*

Address ________________
Street *City* *State* *Zip*

Email Address ________________ Cell Phone ________________

Social Security No. ________________ Birthdate ________________ Age ________ Sex ________

Are you Hispanic, Latino, or of Spanish origin?

☐ Hispanic, Latino or of Spanish origin ☐ Non-Hispanic, Latino or of Spanish origin

What is your race? (One or more may be selected)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ________________

Check Appropriate Box: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Minor

Patient Employment ________________ Business Phone ________________

Employer Address ________________

Spouse's Name ________________ Spouse's Employment ________________

Do you have an advanced directive (living will)? ☐ Yes ☐ No

Referred to our office by: (Check One)

☐ Another Patient *(Name)* ________________

☐ Physician *(Name)* ________________

☐ Primary Care Physician (HMO) *(Name)* ________________

☐ Phone Book ☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ T.V. ☐ Website ☐ Other

Nearest relative/friend *(Not in household)* ________________

INSURANCE POLICYHOLDER INFORMATION *(If different from Patient)*

Name ________________ Relationship to Patient ________________
First *M.I.* *Last*

Address ________________
Street *City* *State* *Zip*

Social Security No. ________________ Birthdate ________________ Home Phone ________________

Employer ________________ Work Phone ________________

Address of Employer ________________
Street *City* *State* *Zip*

RESPONSIBLE PARTY INFORMATION *(If different from above) (Guarantor)*

Name ________________ Relationship to Patient ________________
First *M.I.* *Last*

Address ________________
Street *City* *State* *Zip*

Social Security No. ________________ Birthdate ________________ Home Phone ________________

Employer ________________ Work Phone ________________

Address of Employer ________________
Street *City* *State* *Zip*

PLEASE PRESENT ALL MEDICAL & VISION INSURANCE AND PHOTO IDENTIFICATION CARDS TO RECEPTIONIST

EYE MEDICAL CENTER
7777 Hennessy Blvd., Suite 3000, Suite 3001, Suite 4000 • Baton Rouge, LA 70808 • (225) 766-7441 • (225) 766-7597 (fax)
7539 Corporate Blvd., Suite 100 • Baton Rouge, LA 70809 • (225) 216-1400 • (225) 216-1405 (fax)
11424 Sullivan Road, Bldg. A, Suite A, • Central, LA 70818 • (225) 262-8141 • (225) 262-8142 (fax)
5000 O'Donovan Blvd., Suite 407 • Walker, LA 70785 • (225) 665-1777 • (225) 665-4777 (fax)
1615 S. W. Railroad Avenue • Hammond, LA 70403 • (985) 345-0050 • (985) 345-5800 (fax)

H. Michael Haik, Jr., M.D. • Allen R. Pearce, M.D. • Suzanne S. Luckett, M.D. • Thomas J. Heigle, M.D. • David P. Fargason, M.D.
Philip D. Ehrlich, M.D. • Candace C. Collins,M.D. • George D. Fivgas, M.D. • Annette M. Rhodes, M.D. • Daniel H. Nelson, M.D.
Michael Abbott, O.D. • R. Lucas Patin, O.D. • Jamie L. Hatcher, M.D. • Devin B. Tran, M.D. • Daniel J. Dodson, M.D.
Laurén Luckett Dardar, O.D. • John Paul Luckett, M.D.

PATIENT: ______________________________ Account No. ____________________

ASSIGNMENT OF MEDICARE BENEFITS:

I request that payment of authorized Medicare benefits be made on my behalf to Eye Medical Center for any services furnished to me by the physicians of Eye Medical Center. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services, the government Medicare agency, and its agents any information needed to determine these benefits or benefits for related services. This authorization is effective indefinitely unless I revoke this arrangment.

SERVICES NOT COVERED BY MEDICARE

REFRACTION (an examination to determine if you need glasses or a change of lenses)
EXAM WITHOUT MEDICAL NECESSITY (exam only for the need of glasses)

I understand that I will be responsible for payment in full for these services at the time these services are rendered.

X ______________________________________
Patient Signature

Date ______________________________________

SERVICES NOT COVERED BY PEOPLE's HEALTH (Ophthalmologist only)

I understand that I will be responsible for payment in full for these services at the time these services are rendered.

X ______________________________________
Patient Signature

Date ______________________________________

ASSIGNMENT OF MEDICAL INSURANCE BENEFITS:

I request that payment of authorized medical benefits be made on my behalf to Eye Medical Center for any services furnished to me (or my child) by the physicians of Eye Medical Center. I authorize any holder of medical or other information about me (or my child) to release to my insurance carrier(s) any information needed to determine these benefits or benefits for related services. This authorization is effective indefinitely unless I revoke this arrangment.

I understand that I will be responsible for payment at the time of service of any deductibles, co-insurance, and/or any non-covered services not payable by my insurance carrier(s). I further understand that most insurance carriers will not pay for an examination for glasses or for a change of lenses.

X ______________________________________
Patient Signature

Date ______________________________________

EYE MEDICAL CENTER ("EMC")
A Professional Medical Corporation

DESIGNATION OF PERSONAL REPRESENTATIVE

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing this authorization you are informing us of your designation of the named person as your personal representative. This designation may be revoked at any time by signing and dating the revocation of your copy of the form and returning it to this office.

Representative No. 1:

I, ________________________________ hereby designate ________________________________ to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative's SS No: __________

Representative's Date of Birth: ______________________

Representative's Driver's License No. or other Picture ID No.: ______________________

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: ____

____

REVOCATION of Representative No. 1

I hereby revoke this designation of a personal representative.

Patient Signature: ______________________

Date: ______________________

Representative No. 2:

I, ________________________________ hereby designate ________________________________ to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative's SS No: __________

Representative's Date of Birth: ______________________

Representative's Driver's License No. or other Picture ID No.:

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: ____

____

REVOCATION of Representative No. 2

I hereby revoke this designation of a personal representative.

Patient Signature: ______________________

Date: ______________________

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to **EYE MEDICAL CENTER**, 7777 Hennessy Blvd., Suite 4000, Baton Rouge, Louisiana 70808. I further understand that such revocation does not apply to the extent that persons who have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

______________________ ______________________

Patient Signature Date

Last Four Digits of SS #: ______________ Date of Birth: ______________

You May Mail to: **Attn: HIPAA Information**
Eye Medical Center
7777 Hennessy Boulevard, Suite 4000
Baton Rouge, Louisiana 70808
Fax Number: (225) 766-7597

EMC
EYE MEDICAL CENTER
Medical Excellence Since 1946

ROUTINE EXAM vs. MEDICAL EXAM REFRACTION

Your symptoms/visual complaints, or lack of, will determine if your vision exam is coded as "Routine" or "Medical". The decision to file as routine or medical must be made the day of your eye examination. Eye Medical Center will not alter chart notes at a later date to change which plan your exam is to be billed to.

ROUTINE EXAM - A routine exam, by definition, is an exam for people who have no eye disease or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contact lenses) and any potential indicators of eye disease. If your doctor finds anything abnormal during your vision exam, further testing using your medical insurance will be needed.

Routine eye examinations through most Vision Plans require prior authorization. You must provide Eye Medical Center with your Vision Plan policy information prior to services.

MEDICAL EXAM - Exam for evaluation of a medical-related complaint or follow-up of an existing medical condition. Examples that will necessitate your visit being submitted to your medical insurance include headache, eye irritation, dry eyes, floaters, glaucoma, cataract, double vision, macular degeneration, high risk medications, etc.

REFRACTION
Refraction is a test that measures the eyes' need for corrective lenses and also assists in monitoring certain medical conditions of the eye. The results of the refraction are used to provide a prescription, if necessary, for eyeglasses. This test, however, will not provide sufficient information to write a contact lens prescription, which requires a contact lens fitting.

Insurance companies separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. Typically, vision plans cover both the exam and the refraction, while medical policies cover only the exam. Medicare enforces the policy of requiring eye doctors to separately charge and collect for refractions. As many private insurance carriers adopt the policies of the federal government, many of our contracts with private insurance carriers now require us to separately collect for this non-covered service also.

We hope this information will help you understand how your visit will be submitted to your insurance for today's visit and all future visits. If you are uncertain about your vision/medical benefits, please contact your insurance carrier.

______________________________ ______________
SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE