

Dear Patient:

Thank you for choosing the Rowan Eye Center for your ophthalmic care. The staff makes every effort to provide you with personalized service while ensuring compliance with HIPAA guidelines. To better serve you, please fill out the following forms to the best of your ability. Should you require further assistance, please speak with our front desk nurse.

**Patient Information**

1. Patient's Name: \_\_\_\_\_  
First
Middle
Last

2. Patient Information Only:  
 a. Patient's Address: \_\_\_\_\_  
Number and Street

\_\_\_\_\_ City State Zip Code

b. Patient's Sex: (Please check.)  Male  Female

c. Patient's Home Phone: \_\_\_\_\_

d. Patient's Work Phone: \_\_\_\_\_

e. Patient's Mobile Phone: \_\_\_\_\_

f. Patient's Email: \_\_\_\_\_

g. Patient's Marital Status: (Please check one.)  Single  Married  
 Legally Separated  Divorced  Widowed

h. Patient's Date of Birth: \_\_\_\_\_

i. Patient's Social Security Number: \_\_\_\_\_

3. Do you have a legal guardian or does someone other than yourself have power of attorney? (Please check.)  
 Yes (If yes, please proceed to **number 4.**)  No (If no, please proceed to **number 5.**)

4. Legal Guardian Information Only:

a. Legal Guardian's Name: \_\_\_\_\_  
First
Middle
Last

b. Legal Guardian's Address: \_\_\_\_\_  
Number and Street

c. Legal Guardian's: \_\_\_\_\_  
City State Zip Code

d. Legal Guardian's Sex: (Please Check.)  Male  Female

e. Legal Guardian's Date of Birth: \_\_\_\_\_

f. Legal Guardian's Social Security Number: \_\_\_\_\_

g. Legal Guardian's Phone Number: \_\_\_\_\_

**Please check one box and proceed to Page 3.**

**Referrals**

5. How were you referred to the Rowan Eye Center?

- Billboard
- Emergency Room
- Insurance Company
- Medical/Osteopathic Physician (MD/DO) My referring physician is Dr. \_\_\_\_\_  
First Name Last Name
- Neighbor
- Optometrist (OD) My referring physician is Dr. \_\_\_\_\_  
First Name Last Name
- Pasco Medical Guide 2008
- Patient
- Queen of Peace Newsletter
- Radio Advertisement
- St. Pete Times
- St. Vincent de Paul Newsletter
- Suncoast News
- Television Advertisement
- Village Lantern
- Website
- Yellow Pages
- Other (Please specify.) \_\_\_\_\_



**New Patient Forms**

**Please Sign at Arrows**

**PERMISSION FOR TREATMENT**

I, understand and hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by **Rowan Eye Center, Inc.** as deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records for treatment purposes at the Rowan Eye Center. Our primary concern as your healthcare provider is to provide you with the best possible care. Follow-up visits and services for treatment of your medical problems are scheduled to provide that care. On occasion, your insurance company may limit the number of visits, services, or drugs for which it will reimburse. However, more frequent visits and services, or specific drugs may be needed to properly treat your condition. Your insurance company may consider these visits, services or specific drugs “not reasonable and necessary” under your policy, and may deny payment for them.

In particular, please note that the annual exam is considered by insurance companies to be a health screening and wellness visit. Many patients, quite logically, use this visit to discuss other problems, such as visual abnormalities, eyelid abnormalities, skin cancer concerns, and many others. There are proper billing codes to reflect these additional services, which we will submit. Some health plans, however, will not cover additional services which may be ultimately denied by the insurer for this visit. Unfortunately, we are unable to verify ahead of time whether or not charges for these services will be covered or denied by your insurer. Some insurance plans will cover the additional services only if performed in a separate visit. You have the option to schedule a separate appointment to discuss these issues with your physician. However, unless you instruct us otherwise, we assume that you wish to have all the issues addressed at this time, and are happy to do so, if the schedule permits. Thus we will proceed accordingly. Please be aware, however, that if your health plan denies payment for these services, payment of these charges will be your responsibility. Since we believe each scheduled visit and service provided in our office is both reasonable and necessary, we will try to assist you in collecting these charges from your insurance company in the event that payment is denied. However, you will be personally responsible for payment if your insurance requires that you indicate your agreement by reading and signing the following paragraph:

“I have been informed by Rowan Eye Center, Inc. that my insurance may deny payment for services provided to me today. Since both Rowan Eye Center, Inc. and I believe these services are necessary for the proper treatment of my condition, I agree to be personally and fully responsible for payment of these services in the event my insurance does deny payment.”

➤ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND ASSIGNMENT**

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by Rowan Eye Center, Inc. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services. I hereby authorize Rowan Eye Center, Inc. to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier (S)/Medicare to make payment directly to Rowan Eye Center, Inc. for medical/diagnostic/surgical benefits payable for the services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances that such payment will be made to this physician’s office for services. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or other personal information.

➤ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DESIGNATED RELATIVE**

I authorize discussion of my general medical condition, diagnosis, treatment, payment and healthcare operations with my:

Spouse       Children       Other \_\_\_\_\_

Please list the family member or significant others, if any, whom we may inform about your medical condition.

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**PRIVACY NOTICE**

I have received a copy of Rowan Eye Center, Inc.’s office privacy notice as required by HIPAA.

➤ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**New Patient Forms**  
**Please Sign at Arrows**

**REFRACTION POLICY**

Refraction is the process of determining the eye's need for corrective glasses. It is an essential part of an eye examination, but it is **NOT** a covered service by most insurance companies, including Medicare. Our fee to perform a refraction is **\$25.00**. This fee is collected in addition to the patient's co-pay.

**ACKNOWLEDGMENT**

I have read the above information and understand that the refraction is a **NON-COVERED SERVICE**. I accept full responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

Patient Name: \_\_\_\_\_

➤ Patient Signature (Or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

➤ Patient Signature (Or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_