WELCOME TO BUFFALO EYE CLINIC/MARSHFIELD EYE CLINIC

Name: _____
Last First Middle

Mailing Address: _____

City:_____ State:_____ Zipcode:_____

Home Phone #:(_____)_____ Cell Phone #:(_____)_____

Email address:_____ Marital Status: Single / Married / Widowed / Child

Sex: M / F Date of Birth:_____ Age:_____ Social Security #:_____

Spouse / Parent or Guardian: _____Date of Birth:_____

Address: _____

_____

Phone#: (_____)_____

Employer: _____

Address:_____

Phone#: (_____)_____

INSURANCE: Medicare / Medicaid / Vision Insurance / Medical Insurance (ALL MAY APPLY)

_____

(WE NEED TO COPY ALL OF YOUR INSURANCE CARD(S)

Who referred you to our office?_____

Emergency contact: (This number needs to be other than home number)

Name:_____

Relationship to patient:_____

Address: _____

_____

Phone#:(_____)_____

PLEASE COMPLETE PAGE 2

MEDICAL HISTORY

Physician's Name:_____ Phone#:_____

PLEASE CHECK HISTORY THAT APPLIES TO YOU OR YOUR IMMEDIATE FAMILY
(Grandparents, Parents, Siblings)

____Diabetes	____Blood Transfusions	____Heart
____Cataracts	____Blindness/Partial Blindness	____HIV
____Glaucoma	____High Blood Pressure	____Thyroid
____Asthma	____Rheumatic Fever	____Epilepsy
____Hepatitis	____Tuberculosis	

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Do you wear glasses / contacts? YES / NO If yes, Full-time / Part-time

Do you need new glasses? YES / NO, new contacts? YES / NO, sunglasses? YES / NO

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Are you having a medical eye problem? YES / NO If yes, please list:_____

_____

Any previous eye surgeries? YES / NO If yes, please list:_____

_____

Any previous eye injuries? YES / NO If yes, please list:_____

_____

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Are you using any eye medication (prescribed or over the counter)? YES / NO If yes, please list:

_____

Are you taking any other medications (prescribed or over the counter? YES / NO If yes, please list:

_____

_____

Are you allergic to any medications? YES / NO If yes, please list:_____

_____

PLEASE COMPLETE PAGE 3

NON-DISCRIMIMATION POLICY STATEMENT

It is the policy of Kramer & Newcomb, O.D., P.C. to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. No person shall be excluded for participation in, or be denied the benefits of any service, or be subject to discrimination because of race, color, national origin, religion, sex, age, or disability.

COMPLAINT PROCEDURE

If you believe you have been denied a benefit of service because of your race, color, national origin, religion, sex, age or disability, you may file a Complaint of Discrimination with the Office or Facility Administrator, either verbally or in writing. If you choose to file your complaint in writing, please include your name, address, telephone number and brief description of what occurred which led you to believe you were discriminated against. You may also file a Complaint of Discrimination by contacting either of the external agencies listed below:

Department of Social Services
Office of Civil Rights
PO Box 1527
Jefferson City, MO 65102
573-751-9092 or 800-8041 or 800-877-6916 (TDD)

Department of Health and Human Services
Office of Civil Rights
601 East 12th Street
Kansas City, MO 64106
816-426-7277

You will not be intimidated, harassed, threatened or suffer any penalty because you file a complaint. Any penalty or reprisal against you or any other involved person(s) is prohibited by law.

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ASSIGNMENT & RELEASE

Our office accepts **Medicare** and **Medicaid** for those services which these two agencies cover. Just like any private insurance plans you have had, **Medicare** requires you to pay a portion of your medical bills.

1. **Medicare** requires you to pay your Medicare deductible each year. **Medicare** also requires you pay 20% after you have paid your Medicare deductible. This is called your Medicare co-insurance. In order to maintain our reasonable fees, we request that you pay this 20% when services are rendered unless you have a secondary insurance that covers your deductible or coinsurance.

2. **Medicaid** has no yearly deductible, but has a cost-share for adults, for each office visit and additional cost-share for glasses. In order to maintain reasonable fees, we request that you pay the cost-share when services are rendered.

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AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to all providers of the vision and/or medical benefits, if any, otherwise payable by me for services rendered by Buffalo Eye Clinic.

I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any cost incurred in the collection of such account, including reasonable attorney fees and court costs. I hereby waive notice of dishonor, demand and protest. All exemptions are waived.

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I, the undersigned, hereby acknowledge that is the policy of this office that full payment may be made at each visit and I am responsible for payment to BUFFALO EYE CLINIC/MARSHFIELD EYE CLINIC for all services rendered by the above patient that are not covered by Medicare assignment, Medicaid, Workman's Compensation or any other benefits agreed to by the provider of such services.

I certify that the information here in is complete and correct.

Any delinquent accounts over 30 days old will have a finance charge of 1.5% per month.

PAYMENT IS DUE AT TIME OF SERVICE

I, hereby authorize photocopies of this form to be valid as the original.

_____ _____

Patient/ Responsible Party Signature Date

_____

Relationship to patient