Cabot Family Eye Care

Patient Financial Responsibility

- I understand and agree that I am financially responsible for all charges and for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services, and other screening ordered by the doctor or staff.

- I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

- I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

- I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

- I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

Printed Name (Guardian if applicable)	Signature	Date

Cabot Family Eye Care Witness Signature

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Cabot Family Eye Care provides this form to comply with the Health Insurance Potability and Accountability Act of 1996 (HIPAA).

Printed Name (Guardian if applicable)	Signature	Date

I give permission to communicate my Private Healthcare Information to:

Name	Relationship
Name	Relationship

Cabot Family Eye Care

Patient's Name _____ Today's Date _____

Preferred Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work _____

Email _____

Social Security Number _____ Sex _____ Marital Status _____

Patient's Employer/School _____ Occupation _____

****

Primary Medical Insurance _____ Member ID _____

Insurance Policy Holder _____ Date of Birth _____

Secondary Medical Insurance _____ Member ID _____

Insurance Policy Holder _____ Date of Birth _____

Vision Insurance _____ Member ID _____

Insurance Policy Holder _____ Date of Birth _____

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How were you referred to us?

____ Family ____ Friend ____ Co-Worker ____ PCP ____ Staff Member ____ Dr. Livengood ____ Other

____ Health Plan ____ Direct Mail ____ Yellow Pages ____ Location/Sign

Whom may we thank for referring you? _____

Other Family Members

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Emergency Contact _____ Phone _____

Cabot Family Eye Care

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Current Medications: _____

_____

Ocular Medications: _____

Drug Allergies: _____

Family and Patient's Current Medical History
(Please check all of the following that apply to family or your current medical history)

	Family	Self		Family	Self
Glaucoma	_____	_____	Diabetes	_____	_____
Cataract	_____	_____	High Cholesterol	_____	_____
Macular Degeneration	_____	_____	Thyroid	_____	_____
Retinal Detachment	_____	_____	Cancer	_____	_____
Blindness	_____	_____	High Blood Pressure	_____	_____

Past or Current Patient Medical Conditions

General: _____ Ear/Nose/Throat: _____

Cardiovascular: _____ Respiratory: _____

Kidney/Bladder: _____ Musculoskeletal: _____

Gastrointestinal: _____ Neurological: _____

Skin: _____ Psychiatric: _____

Endocrine: _____ Blood/Lymphatic: _____

Allergic: _____ Immunological: _____