Welcome to Central Montana Eyecare

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your eye health.

Patient Information

Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Marital Status: Single Married Widowed Divorced Other

Date of Birth: _____ Age: _____ Race: _____

Employer _____ Occupation _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

****IF YOU HAVE INCLUDED A CELL PHONE, YOU ARE GIVING OUR OFFICE OR ASSIGNEE PERMISSION TO CALL THAT PHONE****

E-mail: _____ Hobbies: _____

Whom may we thank for referring you? _____

Notify in case of an emergency _____ Home phone: _____ Work Phone: _____

Please check your preferred method of contact: Phone call_____ Text message_____ E-mail_____

We offer several payment options including: Cash, Check, VISA, Mastercard, American Express, Discover, and Care Credit.

Person Responsible for Account (Guarantor)

Name: _____ Phone: _____

Address if different from above: _____

City: _____ State: _____ Zip: _____

Insurance Information

Medical Insurance Company: _____ ID # _____

Vision Insurance Company: _____ ID # _____

Policy Holder Name: _____ SSN: _____ DOB: _____

Address if different from above: _____ Phone: _____ Work phone: _____

Flex or Cafeteria Plan? Yes_____ No_____

Additional Insurance: We do not bill secondary insurance, but will assist you in filing the claim.

Is the patient covered by secondary insurance? Yes_____ No _____ Insurance Company: _____

Policy Holder Name: _____ Date of Birth: _____

Subscriber # _____ Group # _____

Revised: 10/09/2020

Patients with Tricare:

I understand that I am financially responsible for charges for services which are not covered by Tricare. I understand that Tricare does not pay for routine contact lens services.

Signed: _____ Date: _____

Name of Primary Care Manager _____

Patients with Medicaid:

I understand that I am financially responsible for charges for services which are not covered by Medicaid. I understand that Medicaid does not pay for routine contact lens services. Recipients on BASIC Medicaid do not qualify for routine vision services. I understand that I may order glasses outside the Medicaid system for which I will be financially responsible.

Signed: _____ Date: _____

Consent for treatment: I consent to treatment deemed advisable by Central Montana Eyecare Providers. Further testing and follow up appointments for treatment and diagnosis will result in additional fees.

Authorization for the Release of Medical Information: I hereby authorize CME to release all information necessary to secure the payment of benefits.

By including a cell phone, I am giving this office or assignee permission to call that phone.

Assignment of Benefits: I assign directly to Central Montana Eyecare all vision/medical benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature: I authorize the use of this signature on all my insurance submissions.

I understand that I am obligated to pay the account regardless of any insurance or third party coverage. I also understand that if the account is referred to a collection agency that I will be responsible for the collection costs and reasonable attorney fees when applicable.

Notice of Privacy Practices: I have read and/or reviewed the notice of privacy practices made available by CME.

All authorizations remain in effect until revoked in writing by either party.

Signed: _____ Date: _____

CONSENT TO RELEASE MEDICAL RECORDS/INFORMATION:

I,_____, hereby authorize Central Montana Eyecare PC to disclose protected

health information to_____. This authorization for release of medical information

covers all past, present and future periods until revoked in writing.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature:_____ Date: _____

Printed name of patient or personal representative and his or her relationship to patient_____

_____ Date: _____

Revised: 10/09/2020