

Digby Eye Associates
Patient Information Form

Name _____ SS# ____ - ____ - ____ Male/Female _____

Age ____ Date of Birth ____ / ____ / ____ Marital Status ____ Home Telephone _____

Mailing Address _____ City _____ State _____ Zip _____

Employer _____ Work Telephone _____

Employed: Fulltime / Part-time Student: Fulltime / Part-time Email address _____

Name of Spouse _____ SS# ____ - ____ - ____ Spouse Birthday ____ / ____ / ____

Spouse Employer _____ Spouse Work Telephone _____

Referring Source: Family __ Friend __ Ins. __ Yellow Pages __ TV __ Radio __ Other Ad __ MD __ OD __

Referred by MD or OD – Complete Name _____

Contact in case of emergency: Name _____ Phone _____

Self pay and patients with insurance, please complete and sign below

Please let us make a copy of your insurance card(s)

Primary Insurance Carrier _____

Secondary Insurance Carrier _____

Is this plan through an employer? No / Yes Employer _____ Self/Spouse/Parent

I hereby authorize release of any information necessary to process this claim and request that payments of benefits be made either to myself or to the party who accepts assignment. A copy of this authorization will remain on file for all future treatment. I authorize said assignee to release all information to secure payment.

Signature: _____ Date: _____

FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Donald J. Digby, MD, PA for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

FOR MEDICAID PATIENTS ONLY

The North Carolina Medicaid Program requires us to inform you before a physician at Digby Eye Associates sees you, that this office does not accept Medicaid for the purchase of eyeglasses. You will be given a prescription for glasses that you may take to an optical shop that accepts Medicaid. You have the right to see another physician who may be able to provide both your eye exam and make your eyeglasses.

I understand the information above and I want to have my eye exam with Digby Eye Associates. I understand that I will need to have eyeglasses made elsewhere.

Signature: _____ Date: _____

DIGBY EYE ASSOCIATES

FINANCIAL POLICY

At Digby Eye Associates, it is our goal to provide you with the best eye care services available. Over the past year, insurance companies have decreased provider payments for services and some insurance companies have refused to pay for many types of diagnostic tests even though those tests are medically indicated and not considered experimental.

Co-pays are expected when you check in with the receptionist. If you do not have your co-pay with you, your appointment will be rescheduled. For your convenience, we accept cash, personal checks, Visa and MasterCard. There is a \$25.00 charge for returned checks.

Diagnostic testing is a very important tool which aids your physician in the diagnosis and treatment of many ocular problems. If you have questions about the costs of diagnostic testing, please ask the technician before tests are performed.

We participate in many insurance plans. It is your responsibility to check with your insurance company to be sure the physician that you are seeing participates with your plan.

Any balance not paid by your insurance company is the responsibility of the patient and you will be billed after we receive payment from your insurance company. Patient balances are expected to be paid in 30 days after billed. **Balances not paid after 120 days will be forwarded for collections.**

Signature of Patient or Responsible Party

Relationship if Not Patient

Date