

BLUE RIDGE EYE SPECIALISTS, PC

Alan J. Fink, MD · Michael J. Deiboldt, OD

PATIENT REGISTRATION

Please Print

Last Name _____

First Name _____ Middle Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Other Contact # _____

Birth Date _____ Age _____ Sex _____ Social Security # _____

Emergency Contact _____ Phone # _____ Your Marital Status _____

Patient's Employer _____ Full-Time or Part-Time? _____

Employer's Address / Phone # _____

Your Family Doctor _____

Doctor's Address / Phone # _____

Your Pharmacy / Location _____

Referred By _____ Last Eye Exam _____

DISCLOSURE TO FAMILY/FRIENDS

Please check appropriate box(es) and name any individuals with whom you would like us to share information

I authorize Blue Ridge Eye Specialists to discuss medical information and/or financial information related to my health care with _____.

SIGNATURE OF GUARANTOR

I hereby authorize Blue Ridge Eye Specialists, PC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to me or to my dependents. I understand that I am responsible for my bill for treatment regardless of whether or not my insurance company pays. I agree to pay any and all attorney's fees, collection fees, court costs and interest that Blue Ridge Eye Specialists, PC may incur on any balance that remains unpaid for thirty (30) days after due date.

Responsible Party _____ Date _____

MEDICARE LIFETIME FORM

I request that payment under the Medicare Insurance Program be made either to me or on my behalf to Blue Ridge Eye Specialist, PC for any services furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine those benefits or the benefits payable for related services.

Beneficiary Signature _____ Date _____

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**NOTICE TO OUR PATIENTS
ON REFRACTIONS AND ROUTINE EXAMINATIONS**

A Refraction is the process by which the doctor determines whether you need glasses or if you require a change in your present glasses prescription. This should not be confused with the Eye Examination which determines the health of the eye and may check for conditions such as cataracts and glaucoma.

Medicare, in most cases, covers the Eye Examination if you have a specific eye complaint or if you are being followed for an ongoing eye condition. However, Medicare and most private insurance carriers do not cover Refractions or Routine Eye Examinations. These charges may appear on your insurance carrier Explanation of Benefits as non-covered charges.

According to the Medicare Coverage and Limitations Manual:
“Expenses for all refractive procedures, whether performed by an ophthalmologist or an optometrist and without regard to the reason for the performance of the refraction, are excluded from coverage.”

I have read and understand the above and agree to pay for any charged which Medicare or my private insurance company deems to be non-covered.

Patient's Signature _____ Date _____