MOORE EYE CLINIC

PATIENT INFORMATION

Title: Dr. Mr. Mrs. Ms. Prof.

Patient's name: _____ Preferred name: _____

Date of birth: _____ Social Security number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Alt. phone: _____ Email Address: _____

May we text and/or email you reminders for appointments and orders? Yes No

Employer: _____ Occupation: _____

Primary Insurance: _____ Secondary Insurance: _____

How did you learn about our office?

_____ Individual: Whom may we thank? _____

_____ Insurance Plan List _____ Phone Book _____ Facebook _____ Google

GUARANTOR INFORMATION

Is the patient responsible for the bill? Yes No If no, then:

Guarantor name: _____ Phone: _____

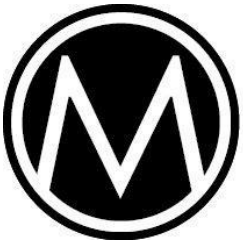
Address: _____ Relationship: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

FINANCIAL POLICY

Payment for services and materials is expected at the time of your visit. Major medical will cover your office visit if you have a medical diagnosis, but it will not cover routine care. Vision care plans will often provide benefits towards routine exams, frames, spectacle lenses or contacts. Our office is in-network with the following vision insurance plans: Blue Cross Blue Shield of Alabama, Southland, and Vision Service Plan. Account balances over 90 days old will be turned over for collection and you will be responsible for collection costs.

Signed: _____ Date: _____



MOORE
EYE CLINIC

PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Date of Birth: _____

Robert L. Moore, OD, staff, employee or representative of Moore Eye Clinic has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)

I acknowledge that I have been notified of the privacy act, which is observed by Dr. Moore and his staff at Moore Eye Clinic.

A copy of the notice will be provided at the patient's request.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Moore Eye Clinic or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

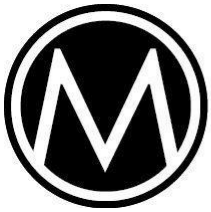
Patient Signature _____ Date: _____

MOORE EYE CLINIC

PATIENT NAME: _____ **DOB:** _____

Please list any and all medications that you currently take. If you have a current list and would like to bring it, please feel free to do so.

	Medication	Dosage	Quantity	Reason
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				



MOORE
EYE CLINIC

631 Helen Keller Blvd, Suite 100
Tuscaloosa, AL 35404
Phone: 205.758.1966
Fax: 205.758.1548

MEDICATION RELEASE REQUEST

In accordance with Meaningful Use Policy, I hereby authorize the release of my official medication list to Robert L. Moore, O.D.

Name of Patient: _____

Patient's Date of Birth: _____

Patient's Address: _____

Primary Care Doctor: _____

Patient Signature: _____ Date: _____

MOORE
EYE CLINIC

REFRACTION SERVICE AND FEE

An important part of your eye exam is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is *NOT* a covered service by Medicare and many other insurance plans. The cost of the refraction is $35, and this fee will be collected at the time of service.

PATIENT ACKNOWLEDGMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service.

_____ _____

Patient Signature Date