Bay Eye Clinic P.C.

3585 Broadway North Bend, OR 97459
(541) 756-2584 FAX (541) 756-5783
1-800-422-9393
www.bayeyeclinic.com

JON C. KINTNER, M.D.
DEBRA A. GRAHAM, M.D.
JANE GILBERT, M.D.

Practice Limited to the Eye
Cataract Surgery & Intraocular Lenses
Board Certified, Members of American
Academy of Ophthalmology

REGISTRATION FORM

Patient Name: _____ DOB: ___/___/___ M☐ F☐ SSN: _____-____-_____

Preferred Contact Method: Home Phone Cell Phone Text Message Email
(Circle one)

Race: American Indian Alaska Native / Asian / Black or African American / White / Native Hawaiian or Pacific Islander
(Circle one)

Decline ☐ Preferred Language: _____ **Ethnicity**: Hispanic or Latino ☐ Non-Hispanic or Latino ☐

Marital Status (circle one): Married Single Widow Divorced

Home Phone #:_____ Cell #:_____ E-mail:_____

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

*Mailing/Secondary Address:_____ City:_____ State:_____ Zip code:_____

Employer:_____ Occupation:_____ Work #:_____ Retired ☐

Primary Care Doctor: _____ PCP Location (city/state):_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Spouse/Responsible Party

Name:_____ DOB: ___/___/___ SSN:_____-_____-_____ Phone:_____

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

Employer: _____ Retired ☐ Patient of Bay Eye Clinic ☐

I authorize Bay Eye Clinic to communicate with the authorized parties listed below about my medical care, billing and glasses/contact lenses prescriptions. This does not authorize the parties' access to obtain medical records as a Release of Medical Records requires authorization from the patient:

_____/_____ _____/_____
(name) (relationship) (name) (relationship)

_____/_____ _____/_____
(name) (relationship) (name) (relationship)

I further authorize for the release of information regarding diagnosis, test results and/or prescriptions to my telephone/text number or to leave a message on my voicemail. I also permit you to contact me by email.

A copy of the HIPAA Privacy Practices is available upon request .

Printed Name: _____ Signature:_____ Date:____/____/____

OVER ->

Bay Eye Clinic Insurance Information and Financial Policy

Primary Insurance Name: _____

Subscriber Name: _____ Relationship to Patient: _____

Employer: _____ Effective Date: _____

Subscriber #: _____ Group#: _____ DOB: ____/____/____

Secondary Insurance Name: _____

Subscriber Name: _____ Relationship to Patient: _____

Employer: _____ Effective Date: _____

Subscriber #: _____ Group#: _____ DOB: ____/____/____

Third Insurance Name: _____

Subscriber Name: _____ Relationship to Patient: _____

Employer: _____ Effective Date: _____

Subscriber #: _____ Group#: _____ DOB: ____/____/____

All professional services rendered are charged to the patient or responsible party. We will bill your insurance company/companies as a courtesy to you, however, the patient or responsible party is responsible for all fees, co-payments, and/or insurance deductibles, as well as any amount not covered by insurance. I hereby authorize Bay Eye Clinic to furnish my insurance company with any information which the insurance company may request concerning my present illness or injury. I authorize payment of medical benefits by the insurance company to be paid directly to Bay Eye Clinic for services rendered. **FOR MEDICARE PATIENTS:** I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine these benefits or benefits for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I know, currently, Medicare will pay 80% of the allowed amount after my deductible has been met. The 20% will be billed to my supplement insurance, if any, and I am responsible for the 20% plus refraction if applicable. Balances over 90 days will be forwarded to our billing service, at which time payments should be made to them. In the event your account becomes delinquent and it is necessary to assign your unpaid balance to a collection agency, there will be a $50.00 fee charged at the time of assignment. In the event legal action is needed to collect your account, you will be responsible for any and all fees associated with court costs, garnishments fees, and/or attorney fees incurred.

A ***refraction*** is the process of determining your best corrected vision and is a necessary part of a comprehensive ophthalmic examination. It is needed to help determine if any optical, medical or surgical treatment may be needed. Medicare and many private insurance companies **DO NOT** cover this service. If a refraction is performed as part of your visit, you will be responsible for payment at the time of service for the fee of the refraction which is $40.00.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____ _____

Signature of Patient or Responsible Party | Please Print the Name of the Patient | Date