YUBA SUTTER EYE CARE

460 Plumas Blvd., Suite 102
Yuba City, CA 95991
(530) 743-7366

PATIENT DEMOGRAPHICS

Patient Name_____ Sex: M F
Home Phone: (_____) _____ Cell Phone (_____) _____
Mailing Address: _____ City: _____ State/ Zip: _____
Soc. Sec#: _____ DOB: _____Status: (circle) S M D W Minor
(Needed for Medicare, Medi-cal, patients w/vision insurance or students covered under parents insurance)
E-Mail Address: _____ Responsible Party: _____
Relationship to Patient: _____ Employed by: _____
Employer Phone: _____ Address: _____
City/State/Zip: _____ Family Physician: _____
Family Physician Phone: _____ Emergency Contact: _____
Relationship: _____ Emergency Contact Phone: _____

Medical Insurance Information:

Primary: _____ **Secondary:** _____
Policy Holder: _____ **Policy Holder:**_____
Date of Birth: _____ **Date of Birth:** _____
SS#: _____ **SS#:** _____
ID#: _____ **Group#:** _____
ID# _____ **Group#:**_____
Relationship: Self Spouse Parent Relationship: Self Spouse Parent
Other _____

ASSIGNMENT OF BENEFITS

- I understand that Yuba Sutter Eye Care will bill my medical insurance carrier for covered services. If Yuba Sutter Eye Care is not contracted with my insurance plan, payment will be due at the time of service, and I will be provided with an itemized statement with which I can bill my insurance carrier.
- I authorize and request that insurance benefits be made directly to Yuba Sutter Eye Care on my behalf for all services furnished to me by any physician employed by Yuba Sutter Eye Care or its affiliates.
- I am aware that I am responsible for the deductible, coinsurance and any non-covered services. Coinsurance and deductibles are based upon the change determination of my insurance carrier/carriers.
- If I do not have insurance I understand that payment will be due at the time of service.
- I understand that I am financially responsible for all charges whether or not paid by my insurance.

RELEASE OF INFORMATION

Insurance authorization, release of medical records, insurance benefits and assignments, responsibility of patient and acknowledgement

- Yuba Sutter Eye Care, employees of its Medical staff (including your physician), and the independent contractor services have agreed, as permitted by law, to share your health information among themselves for the purposes of treatment, payment or health care operations. This enables us to better address your health care needs. This information is being provided to you as a supplement to The Notice of Privacy Practices given to you by Yuba Sutter Eye Care. For the purposes of treatment, payment, or health care operations, I authorize the release of all medical records and any insurance information between Yuba Sutter Eye Care, its affiliates, my family physician, insurance carriers and the Health Care Financing Administration to process claims for related services.
- I hereby authorize said assignee to release information necessary to secure payment.
- I allow for fax transmission and electronic submission of such information.
- A scan and/or photocopy of this assignment will be considered as valid as an original.

CONSENT FOR TREATMENT I have read and fully understand the above consent for evaluation and treatment, financial responsibility, release of medical information and insurance authorization.

_____ _____ _____
Signature of Patient / Parent / Guardian / Conservator Date Reason patient is unable to sign

If you are an established patient, we apologize for any inconvenience, however, we are required to obtain a signature for insurance purposes and update all patient information annually. Thank you.