



\*Dr. Kimberly Molacek and staff are very pleased to **WELCOME** you to our office. We trust you will feel confident in the vision care you will receive while a patient here. We encourage your comments & welcome your referrals.

**PATIENT INFORMATION**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Pref. Language \_\_\_\_\_  
 Occupation/Grade In School: \_\_\_\_\_ Communication  Text  Phone  Email (Email Add. ) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Employer Phone: \_\_\_\_\_ Spouses Name: \_\_\_\_\_ Spouses Birthdate: \_\_\_\_\_  
 If Child: Parents Name: \_\_\_\_\_  
                   Parents Employer: \_\_\_\_\_  
                   Employer Phone: \_\_\_\_\_  
 How did you hear about our office?  
 Friend/Family Member  Insurance Book  Internet  Website  
 Referral Postcard  Yellow Pages  Newspaper  Biz to Biz  Other \_\_\_\_\_

WOULD YOU LIKE TO BE ABLE TO SECURELY VIEW, DOWNLOAD AND TRANSMIT YOUR HEALTH RECORDS  YES  NO  
 EMAIL ADDRESS \_\_\_\_\_  
 \*if you have any questions regarding this service please ask front desk.

**RESPONSIBLE PARTY**

**Do you have insurance?**

<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> Exam <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses	/	<input type="checkbox"/> <b>No</b> (personal payment)
Insurance Company: _____		/	
We will take a photocopy/scan of your card.		/	<i>I understand that I am financially responsible for all charges.</i>
Policy Holder: _____		/	
Date of Birth: _____		/	
Relationship to Patient: _____		/	
Do you have any other insurance? _____		/	
<b>ASSIGNMENT AND RELEASE</b>		/	
<i>I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Molacek Family Eyecare all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges not covered by my insurance. I authorize the use of this signature on all insurance submission.</i>		/	
_____		/	_____
Responsible Party Signature		/	Responsible Party Signature
_____		/	_____
Relationship	Date	/	Relationship                      Date

**EYE HEALTH HISTORY**

Date of last eye exam: \_\_\_\_\_ Do you wear contact lenses?  Yes  No  
 Name of doctor: \_\_\_\_\_ Type: \_\_\_\_\_ Hours/Day: \_\_\_\_\_  
 Do you wear glasses?  Yes  No Are you interested in contact lenses today?  Yes  No  
 If yes:  All the time  Occasionally  
            Reading  Driving  
            Computer  Playing Sports

CONTINUED ON BACK.....

# HIPAA PRIVACY STATEMENT

## Notice of Privacy Practices Receipt

I acknowledge that I was offered/provided a copy of Privacy Practices from Molacek Family Eyecare.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### FOR OFFICE USE ONLY:

We made a good-faith effort to obtain an acknowledgment of \_\_\_\_\_'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- Patient refused to sign (date of refusal) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Communications barriers prohibited obtaining an acknowledgment.
- An emergency situation prevented us from obtaining an acknowledgment.
- Other \_\_\_\_\_

Attempt was made by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# MEDICARE AUTHORIZATION

## MEDICARE:

I request that payment of authorized Medicare benefits be made on my behalf to Molacek Family Eyecare, for services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency shown. Molacek Family Eyecare accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services such as the refraction and glasses.

## MEDIGAP:

I understand that if a MediGap policy or other health insurance is indicated, my signature authorizes release of the information to the insurance or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Molacek Family Eyecare.

Signature \_\_\_\_\_

Date \_\_\_\_\_