MOLACEK
family eyecare

*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:_____

Occupation/Grade In School:_____ Communication ____Text ____Phone ____Email(see box)

Employer:_____ Employer Address:_____

Employer Phone:_____ Spouses Name:_____ Spouses Birthdate:_____

If Child: Parents Name:_____

Parents Employer:_____

Employer Phone:_____

EMAIL ADDRESS _____

*Email address used only for communication with Molacek Family Eyecare. Will not be used for promotions, solicitation or marketing.

How did you hear about our office?

____Friend/Family Member _____ ____Insurance Book ____Internet ____Website

____Referral Postcard ____Yellow Pages ____Newspaper ____Biz to Biz Other _____

RESPONSIBLE PARTY

Do you have insurance?

___Yes ____Exam ____Glasses ____Contact Lenses

Insurance Company: _____

We will take a photocopy/scan of your card.

Policy Holder:_____ Date of Birth:_____

Relationship to Patient:_____

Do you have any other insurance? _____

ASSIGNMENT AND RELEASE

I, the undersigned, ceritfy 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.

_____

Responsible Party Signature

_____

Relationship Date

___No (personal payment)

I understand that I am financially responsible for all charges.

_____

Responsible Party Signature

_____

Relationship Date

EYE HEALTH HISTORY

Date of last eye exam:_____

Name of doctor:_____

Do you wear glasses? ____Yes ____No

If yes: ____All the time ____Occasionally

____Reading ____Driving

____Computer ____Playing Sports

Do you wear contact lenses? ____Yes ____No

Type:_____ Hours/Day:_____

Are you interested in contact lenses today? ____Yes ____No

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 prohibitied 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 Servies and its agents any information needed to determine thsese 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 ageny shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Molacek Family Eyecare.

Signature_____ Date_____