



# M O O R E E Y E C L I N I C

## 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: \_\_\_\_\_



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**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)

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:** \_\_\_\_\_



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**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.

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



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### **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.

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Patient Signature

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Date