SOUTHERN KENTUCKY EYE CENTER (SKEC) TODAY'S DATE: _____

REFERRED BY: ☐ SELF ☐DR. _____

PATIENT NAME: _____

IF PATIENT IS A MINOR, WHO IS THE CUSTODIAL PARENT: NAME/ DOB: _____

DOB: _____ AGE: _____ SS# _____ SEX: ☐MALE ☐FEMALE

MARTIAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE _____

HOME # _____ CELL# _____

SPOUSE'S NAME: _____ DOB _____

SPOUSE'S PHONE# _____

GUARDIAN / POA NAME: _____ RELATION: _____

ADDRESS / PHONE # _____

EMERGENCY CONTACT NAME _____

RELATION _____ EMERGENCY PHONE NUMBER _____

EMAIL ADDRESS: _____

Circle One

RACE: Asian/Black/White/Native / Other/ Unknown / Refuse to Answer

ETHNICITY: Hispanic or Latino / Not Hispanic or Latino / Refuse to Answer

Preferred Spoken Language: English / Spanish / Other _____/ Refuse to Answer

Office / Insurance Policy:

Primary Insurance: _____

Secondary Insurance: _____

CO-PAYS, DEDUCTIBLES, AND PAST DUE BALANCES ARE TO BE PAID AT TIME OF VISIT.

I certify that I have the above coverage and assign directly to SKEC all insurance benefits, if any, otherwise payable to SKEC for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of my signature on all insurance submissions and any insurance related matters. SKEC may use my health care information and may disclose such information to my insurance, their agents, and their internet-based portals for the purpose of obtaining payment for services and determining insurance benefits, co-pays, deductibles and co insurance amounts or the benefits payable related services.

*** Services rendered to minor/dependent patients: We will look to the adult accompanying the patient for payment on the date of service. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply the subscriber's name/address/phone/date of birth and social security number. We request that you inform the subscriber that their insurance has been used.**

***If your account becomes delinquent and collection proceedings occur and you will be 100% liable for any collection fees, attorney and court cost incurred by Southern Kentucky Eye Center to collect said fees from the responsible party.**

***Returned checks are subject to a $30.00 administrative charge.**

*** I have read and understand the financial policy of Southern Kentucky Eye Center, PSC regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulation, policies and procedures.**

SIGNATURE _____ DATE: _____