NEW PATIENT INSTRUCTIONS - **Shorten your check-in time:** Print out form below. Fill out completely and bring this form with a copy of your insurance card to the check-in desk the day of your appointment.

Eye Medical Center
7777 Hennessy Blvd., Suite 4000
Baton Rouge, LA 70808

Account No. ____________________

Date ____________________

Scheduled appointment with: (Check one) ☐ Dr. Afeman ☐ Dr. Crayton Fargason ☐ Dr. Woo ☐ Dr. Haik ☐ Dr. Pearce ☐ Dr. Luckett ☐ Dr. Heigle ☐ Dr. David Fargason ☐ Dr. Ehrlich ☐ Dr. Collins ☐ Dr. Fivgas ☐ Dr. Wood ☐ Dr. Rhodes ☐ Dr. Lamendola ☐ Dr. Geier ☐ Dr. LaMonica ☐ Dr. Abbott

Have you or any member of your household been treated by our physicians before? ☐ Yes ☐ No

If yes, please give name and relationship ____________________

Patient Information - PLEASE PRINT

Name ____________________ Home Phone ____________________
First *Mi* *Last*

Address ____________________
Street *City* *State* *Zip*

Email Address: ____________________ Cell Phone: ____________________

Social Security No. ____________ Birthdate ____________ Age ______ Sex ______

Check Appropriate box: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widow ☐ Minor

Patient Employment ____________________ Business Phone ____________

Employer Address ____________________

Spouse's Name ____________________ Spouse's Employment ____________

Referred to our office by: (Check One)

☐ Another Patient *(Name)* ____________________

☐ Physician *(Name)* ____________________

☐ Primary Care Physician (HMO) *(Name)* ____________________

☐ Phone Book ☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ T.V. ☐ Website ☐ Other

Nearest relative/friend *(Not in household)* ____________________ Telephone ____________

INSURANCE POLICYHOLDER INFORMATION (If different from Patient)

Name ____________________ Relationship to Patient ____________
First *Mi* *Last*

Address ____________________
Street *City* *State* *Zip*

Social Security No ____________ Birthdate ____________ Home Phone ____________

Employer ____________________ Work Phone ____________

Address of Employer ____________________
Street *City* *State* *Zip*

RESPONSIBLE PARTY INFORMATION (If different from above) (Guarantor)

Name ____________________ Relationship to Patient ____________
First *Mi* *Last*

Address ____________________
Street *City* *State* *Zip*

Social Security No ____________ Birthdate ____________ Home Phone ____________

Employer ____________________ Work Phone ____________

Address of Employer ____________________
Street *City* *State* *Zip*

PLEASE PRESENT ALL MEDICAL & VISION INSURANCE CARDS TO RECEPTIONIST.

EYE MEDICAL CENTER
7777 Hennessy Blvd., Ste 4000, Baton Rouge, LA 70808 - (225)766-7441 - (800)521-5708

Charles E. Afeman, M.D. - Crayton A. Fargason, M.D. - Fay L. Woo, M.D. - H. Michael Haik, Jr., M.D.
Allen R. Pearce, M.D. - S. Shaye Luckett, M.D. - Thomas J. Heigle, M.D. - David P. Fargason, M.D.
Philip D. Ehrlich, M.D. - Candace C. Collins, M.D. - George D. Fivgas, M.D. - Jeremy J. Wood, M.D.
Annette M. Rhodes, M.D. - Joseph A Lamendola, O.D. - Dr. Glen LaMonica, O.D. - Michael Abbott, O.D.

PATIENT:______________________________ EMC #____________________

ASSIGNMENT OF MEDICARE BENEFITS:

I request that payment of authorized Medicare benefits be made on my behalf to Eye Medical Center for any services furnished to me by the physicians of Eye Medical Center. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services, the government Medicare agency, and its agents any information needed to determine these benefits or benefits for related services. This authorization is effective indefinitely unless I revoke this arrangement.

SERVICES NOT COVERED BY MEDICARE:

REFRACTION (an examination to determine if you need glasses or a change of lenses)

EXAM WITHOUT MEDICAL NECESSITY (exam only for the need of glasses)

I understand that I will be responsible for payment in full of these services at the time these services are rendered.

X______________________________
Patient Signature

Date ______________________________

SERVICES NOT COVERED BY PEOPLES HEALTH (Ophthalmologist only)

REFRACTION (an examination to determine if you need glasses or a change of lenses)

I understand that I will be responsible for payment in full of these services at the time these services are rendered.

X______________________________
Patient Signature

Date ______________________________

ASSIGNMENT OF MEDICAL INSURANCE BENEFITS:

I request that payment of authorized benefits be made on my behalf to Eye Medical Center for any services furnished to me (or my child) by the physicians of Eye Medical Center. I authorize any holder of medical information about me (or my child) to release to my insuranceto release to my insurance carrier(s) any information needed to determine these benefits or the benefits payable for related services. This authorization is effective indefinitely unless I revoke this arrangement.

I understand that I will be responsible for payment at the time of service of any deductibles, co-insurance, and/or any non-covered services not payable by my insurance carrier(s). I further understand that most insurance carriers will not pay for an examination for glasses or for a change of lenses.

X______________________________
Signature of Patient or Guardian

Date ______________________________

EYE MEDICAL CENTER ("EMC")
A Professional Medical Corporation

DESIGNATION OF PERSONAL REPRESENTATIVE

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing this authorization you are informing us of your designation of the named person as your personal representative. This designation may be revoked at any time by signing and dating the revocation of your copy of the form and returning it to this office.

Representative No. 1:

I, ________________________________ hereby designate ________________________________ to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative's SS No: __________

Representative's Date of Birth: ________________________

Representative's Driver's License No. or other Picture ID No.: ________________________

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: ____

____

REVOCATION of Representative No. 1

I hereby revoke this designation of a personal representative.

Patient Signature: ____________________________

Date: ____________________________

Representative No. 2:

I, ________________________________ hereby designate ________________________________ to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative's SS No: __________

Representative's Date of Birth: ________________________

Representative's Driver's License No. or other Picture ID No.:

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: ____

____

REVOCATION of Representative No. 2

I hereby revoke this designation of a personal representative.

Patient Signature: ____________________________

Date: ____________________________

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to **EYE MEDICAL CENTER**, 7777 Hennessy Blvd., Suite 4000, Baton Rouge, Louisiana 70808. I further understand that such revocation does not apply to the extent that persons who have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

________________________________ ________________________________

Patient Signature Date

Last Four Digits of SS #: ____________________ Date of Birth: ____________________

You May Mail to:

Attn: HIPAA Information
Eye Medical Center
7777 Hennessy Boulevard, Suite 4000
Baton Rouge, Louisiana 70808
Fax Number: (225) 766-7597