PARAGON EYE ASSOCIATES

D. Todd Ford, M.D. • Michael Blair, M.D.
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PATIENT INFORMATION

First Name: _____ MI: ___ Last Name: _____ SSN: _____

Address: _____ Home: ( )

City: _____ State: _____ Zip: _____ Cell: ( )

Birth Date: _____ Marital: _____ Sex: _____ Emergency: ( )

Age: _____ Ethnicity: _____ Race: _____ Email: _____

EMPLOYER INFORMATION

Patient's Occupation: _____ Business Phone: ( )

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Spouse/ Parents if Minor: _____

Employer: _____ Business Phone: ( )

INSURANCE INFORMATION

☐ Medicare ☐ HMO ☐ PPO ☐ Other

Insurance Company (Primary): _____ Policy Holder: _____

Policy Holder's SSN: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Insurance Company (Secondary): _____ Policy Holder: _____

Policy Holder's SSN: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

REFERRAL INFORMATION

PRIMARY PHYSICIAN: _____ PHONE: ( )

PRIMARY EYE CARE DOCTOR: _____ PHONE: ( )

How did you hear about our practice? _____

What is the reason for your visit today? _____

Are you interested in LASIK? ☐ YES ☐ NO

PLEASE READ AND SIGN BELOW:

I hereby authorize the physicians and staff of Paragon Eye Associates to perform procedures necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any and all visits to Paragon Eye Associates. I understand that I am financially responsible for ALL charges arising from services rendered to me by Paragon Eye Associates.

Signature: X _____ **Date:** _____

_____ / / _____

PATIENT'S NAME DATE

RELEASE OF THE INFORMATION

I hereby authorize Paragon Eye Associates to release information concerning my care for purposes of claims to my insurance company of third party payers in regards to my visits at this clinic for purposes of payment of claims.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient _____ Date _____

OR

Signature of other
Responsible Person _____ Date _____

ASSIGNMENT OF BENEFITS

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Paragon Eye Associates to Paragon Eye Associates.

I further hereby authorize payment directly to Paragon Eye Associates or D. Todd Ford, M.D., P.A. from my insurance company, including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for services rendered. I understand that I am financially responsible to Paragon Eye Associates for charges not covered by this authorization.

I will cooperate in seeking, collecting and paying to Paragon Eye Associates all insurance proceeds. If the insurance proceeds cannot be paid directly to Paragon Eye Associates, I agree to collect payment and pay to Paragon Eye Associates within fifteen (15) days of receipt.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient _____ Date _____

OR

Signature of other
Responsible Person _____ Date _____

REFRACTION POLICY

A refraction is the process of determining the eye's refractive error or need for corrective lenses.

It is an essential part of an eye examination if you are not seeing 20/20 unless you have a known condition diagnosed by the physician that impairs you from obtaining that level of vision. It is **not** a covered service by **Medicare** and **some insurance plans**. For those patients whose insurance does not cover this, a fee of $40 will be collected at the time of service, and this fee is collected in addition to the patient's co-payment at the time of your visit. **This fee does not include any professional fees for contact lens fitting or contact lens evaluations.**

ACKNOWLEDGMENT

I have read the above information and understand the refraction is a non-covered service. If a refraction is performed, I accept full financial responsibility for the cost of this service if not covered by my insurance. The co-payment is separate from and not included in the refraction fee.

Signature of Patient (Parent if minor) _____ Date _____