OREGON EYE CONSULTANTS LLC

Keyhan F. Aryah, MD
Robert M. Beardsley, MD
Focal Point Optical

John W. Karth, MD
Peter A. Karth, MD, MBA
Oregon Eye Surgery Center

W. Benjamin Kunz, MD
Allan A. Hunter, MD
Oregon Eye Associates

| | | | |
|---|---|---|---|
| Patient Name | DOB | Gender ☐F ☐M | SSN |
| Address | City | State | Zip |
| Employer | Occupation | Work Phone | |
| Cell Phone | Home Phone | E-mail | |
| Spouse's Name | Spouse's Employer | | |
| Primary Care Physician | PCP Location (City/State) | | |
| Emergency Contact Name *(Not at your address)* | Phone | Relationship | |
| Race: *Please Circle One* | American Indian or Alaska Native | Asian | Black or African American |
| | Native Hawaiian or Pacific Islander | White | Decline to Answer |
| Ethnicity: *Please Circle One* | Hispanic or Latino ethnicity | Non-Hispanic or Latino ethnicity | Decline to Answer |
| RESPONSIBLE PARTY Name | DOB | SSN | Home Phone |
| Address | City | State | Zip |
| Employer | Work Phone | | |
| How did you hear about us? *Please Circle One* | An OEC Patient | Internet | Insurance |
| | Dr._____ | Facebook | Our Website |
| | Phone Book | Other_____ | |

| | | | |
|---|---|---|---|
| MEDICAL INSURANCE Primary | Subscriber | DOB | ID # |
| Secondary | Subscriber | DOB | ID # |
| Tertiary | Subscriber | DOB | ID # |
| VISION INSURANCE Primary/Secondary | Subscriber | DOB | ID # |
| **OR** are we billing: Worker's Comp | Date Occurred | Insurance Company | Claim # |
| Auto Insurance | Date Occurred | Insurance Company | Claim # |

All professional services rendered are charged to the patient or responsible party. We will file claims with the patient's insurance carrier; however, the patient is responsible for all fees, co-payments, and/or insurance deductibles, as well as any amount not covered by insurance. **Payment of co-payments and insurance deductibles is expected when services are rendered unless other arrangements have been made with our business office in advance.**

I request that payment of authorized Medicare benefits be made either to me or to the provider named above for any services furnished me. I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine these benefits or benefits for related services.

Our practice may refer you to an entity in which the referring practitioner has a financial interest. You have the right to choose any facility, diagnostic lab or practitioner. We will honor your decision to seek treatment outside our recommendation; please confirm insurance coverage for your alternate choices.

I hereby assign to the physician, if assignment is taken, all payments for medical services rendered.

I have been offered the HIPAA Privacy Practices.

I give my permission for affiliates of Oregon Eye Associates to speak to the following individuals regarding my healthcare:

_____/_____ *(Name) Relationship*

_____/_____ *(Name) Relationship*

_____/_____ *(Name) Relationship*

_____/_____ *(Name) Relationship*

**Date:**_____ **Signature:**_____ **Printed Name:**_____