BENSON CHEN, MD

16200 SE 38th Street, Ste 108, Bellevue, WA 98006-5232

LAST NAME	FIRST NAME	MI	

ADDRESS	UNIT #	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL ADDRESS	DATE OF BIRTH	AGE

SOCIAL SECURITY #	GENDER ☐MALE ☐FEMALE	MARITAL STATUS ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐LEGALLY SERARATED

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE

OCCUPATION	HOW DID YOU HEAR ABOUT OUR OFFICE? ☐PHYSICIAN________________ ☐PHONE BOOK ☐WORD OF MOUTH ☐WEBSITE ☐OTHER__________

SPOUSE'S/PARTNER NAME	ALTERNATIVE PHONE	PATIENT'S PRIMARY CARE PHYSICIAN
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT ALTERNATE PHONE

IF PATIENT IS A MINOR PLEASE FILL OUT THIS SECTION

RESPONSIBLE PARTY NAME	ADDRESS	CITY	STATE	ZIP

RESPONSIBLE PARTY PHONE NUMBER	ALTERNATE PHONE	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY NAME	INSURANCE ID NUMBER	INSURANCE GROUP NUMBER

INSURANCE ADDRESS	CITY	STATE	ZIP	OFFICE VISIT COPAY

SUBSCRIBER INOFRMATION

SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT

SUBSCRIBER EMPLOYER NAME	EMPLOYER PHONE	SUBSCRIBER ADDRESS (IF DIFFERENT FROM PATIENT)

SECONDARY MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY NAME	INSURANCE ID NUMBER	INSURANCE GROUP NUMBER

INSURANCE ADDRESS	CITY	STATE	ZIP	OFFICE VISIT COPAY

SUBSCRIBER INOFRMATION

SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT

SUBSCRIBER EMPLOYER NAME	EMPLOYER PHONE	SUBSCRIBER ADDRESS (IF DIFFERENT FROM PATIENT)

*****IF PATIENT HAS MEDICARE AND ANOTHER INSURANCE, PLEASE INDICATE IF THE SUBSCRIBER (NOT NECESSARILY THE PATIENT) IS CURRENTLY WORKING, BY PLACING A CHECK MARK IN THIS BOX ☐. THANK YOU. *****

I testify that all information on this sheet is true and accurate to the best of my knowledge.

_______________________________________ ________________

Signature of Patient, Guardian, or Legal Representative Date

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT

I understand that as part of my healthcare, Washington Eye Care originates and maintains paper records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future car or treatment. I understand that this information serves as: a basis for planning my care and treatment; means of communication among the many healthcare professionals who contribute to my care; a source of information for applying my diagnosis and surgical information to my bill; a tool for third party payors to verify services; and, a tool for continuous quality improvement and the overall continuum of my medical care. This release includes but is not limited to the release of information to other physicians' offices, medical facilities, insurance/managed care companies, and the Health Care Financing Administration (for Medicare recipients). I have been provided with NOTICE OF PRIVACY POLICY which provides a more complete description of information uses and disclosures. I understand my rights to: review the Notice prior to signing this consent; to object to the use of my health information for directory purposes; and, request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that Washington Eye Care is not required to agree to restrictions I may apply and that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign or revoke this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Washington Eye Care reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that Washington Eye Care may disclose my name, address, and phone number; the name of my scheduled treating physician; and time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I understand that Washington Eye Care may disclose to third parties (persons in my home) who answer my phone limited protected health information regarding pending appointments, and/or leave a reminder message on my voice mail system or answering machine.

☐ I fully understand and accept the terms of this consent.
☐ I fully understand and decline the terms of this consent.

______________________________ ______________

Signature of patient or guardian Date

____

Please Print Name

I authorize Washington Eye Care to release protected health information, including authorization to discuss account balances and details with the following persons:

Name of Person	Relationship	Date Authorized	Patient Initials

PLEASE READ AND SIGN THIS IMPORTANT INFORMATION

Please understand, billing of insurance companies is a service that our office provides to you for your benefit. Possession of a valid insurance card is not a guarantee or payment. Ultimately, the charge for our services is your responsibility. We will make every effort, on your behalf, to collect payment from your insurance company first. You are responsible for any co-payment at the time of service.

IN ORDER FOR US TO BILL YOUR INSURANCE COMPANY, YOU MUST PRESENT A *CURRENT* INSURANCE CARD FOR US TO PHOTOCOPY. BRING THIS WITH YOU TO YOUR APPOINTMENT.

MEDICARE PATIENTS: Our physician is a Medicare participating provider. This means that we will bill Medicare for the allowed fees. Medicare pays 80% of the allowed fee and the other 20% is either your responsibility or your Medicare Supplement insurance. Medicare patients are also responsible for the annual Medicare deductible and all non-covered services. The law requires that we bill you for any applicable deductible and the 20% patient responsibility portion.

PRIVATE INSURANCE: If you have insurance coverage with a private carrier, we will make every effort to bill your insurance company first. Most medical providers require that you pay first and allow your insurance company to reimburse you. If we are unable to collect payment from your insurance carrier, you will be responsible for the entire bill. You may, of course, elect to pay on the day of the visit and petition your insurance company for reimbursement.

NON-COVERED SERVICES: There are some services that your medical insurance may not or does not cover at all, and payment for these services is your responsibility. The most common of these in an optometry office is a refraction (this is the test that tell us your eye glass prescription). Payment for this service is collected at the time of your visit.

FEE FOR SERVICE: All payments which are your responsibility are due at the time services are rendered. We regret that we are unable to accept payment plans except for emergency cases.

PAYMENT: Our office accepts cash, VISA, Mastercard, American Express, Discover or a personal check. There will be a $25.00 service charge for all returned checks.

I accept financial responsibility for co-payments, deductibles, and non-covered services, and services not covered by my insurance company.

It is my responsibility, where applicable, to secure and maintain referrals for my visits from my primary care physician and to know when such referrals are required.

MEDICAL RECORDS: While some sharing of medical information is essential for proper medical care and reimbursement, I understand that my medical record is protected to the highest levels of confidentiality. I understand that my medical record is the legal property of Washington Eye Care, but that I may request a copy of my records for myself or a third party, given I sign a separate release and allow Washington Eye Care a ten day notice to fulfill my request. There is a $15.00 fee for photocopying records.

I request payment of authorized benefits by my insurance plan to be paid directly to Washington Eye Care, on my behalf, for services furnished to me by Washington Eye Care and request that they submit claims for payment for those services on my behalf to my insurance carrier(s). If my insurance does not pay, I understand that I am responsible for payment in full. My signature below is verification that I understand this agreement.

______________________________ ______________

Patient Signature Date