



Date _____

PATIENT INFORMATION			
First: _____	MI: _____	Last: _____	REQUIRED Date of Birth: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address: _____ Apt: _____ City: _____ State: _____ Zip: _____			
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____			
Employer: _____ Occupation: _____ Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No			
REQUIRED SSN: _____ - _____ - _____ Email Address: _____			
Preferred Pharmacy: _____			
Referred By: <input type="checkbox"/> Physician <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Website _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> OES Patient			
		First Name	Last Name
Emergency Contact Name: _____ Phone: (____) _____			

PHYSICIAN INFORMATION			
Your Primary Care Doctor:	First Name _____	Last Name _____	Phone: (____) _____
Referring Physician:	First Name _____	Last Name _____	Phone: (____) _____

HEALTH INSURANCE INFORMATION		VISION COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Primary Insurance Co: _____	Subscriber Name: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female
ID #: _____	Group #: _____	Subscriber Date of Birth: ____/____/____	
Subscriber SSN: _____ - _____ - _____	Subscriber Employer: _____	Subscriber Occupation: _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Secondary Insurance Co: _____	Subscriber Name: (if different from above) _____		<input type="checkbox"/> Male <input type="checkbox"/> Female
ID #: _____	Group #: _____	Subscriber Date of Birth: ____/____/____	
Subscriber SSN: _____ - _____ - _____	Subscriber Employer: _____	Subscriber Occupation: _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Vision Insurance Co: _____	Subscriber Name: (if different from above) _____		<input type="checkbox"/> Male <input type="checkbox"/> Female
ID #: _____	Group #: _____	Subscriber Date of Birth: ____/____/____	
Subscriber SSN: _____ - _____ - _____	Subscriber Employer: _____	Subscriber Occupation: _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other

I HAVE READ AND UNDERSTAND THE INFORMATION ON THE BACK OF THIS FORM REGARDING PAYMENT AGREEMENTS, RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS, NOTICE OF PRIVACY PRACTICES UNDER HIPAA, INFORMATION REGARDING HMO/IPA PATIENTS AND COLLECTION POLICIES.

X _____ Date: _____
 Patient or Guardian's Signature



Payment Agreement

We accept most insurance plans as a "courtesy". We are happy to file your claims for you; however we encourage you to familiarize yourself with your individual plan. There are thousands of plans and we cannot bend charges for each plan, patient or visit based on your individual plan. If your insurance does not pay as you had expected, please call their customer service center for a detailed explanation as we are unable to guarantee your insurance benefits. Our relationship is with you, the patient, not your insurance company. As a courtesy to you, we will submit a claim to the insurance company for which you have provided billing information. If claims for service provided to you are denied by your insurance company or Medicare, you will be responsible for payment. If your insurance company requires a referral from your Primary Care Physician and we do not receive the referral, you will be responsible for payment.

Your deductible and co-payments are due at the time of service. Services not covered by insurance, including deductibles and coinsurances, are also due upon request. It is understood and agreed that I will reimburse Oregon Eye Specialists, P.C. for the costs of any and all co-payments, co-insurance, deductibles, non-covered services, non-allowed services, excluded services, denials due to pre-existing conditions, denials due to elective services, and any other costs not reimbursed in full by my insurance carrier within 10 days of receipt of an account statement.

If you do not have health insurance coverage, payment is due at the time of service and a discount may be given. If a statement must be sent, no discount will be given. We accept cash, check, Visa/MasterCard, Discover, and American Express.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact an account representative at 503-244-1232 promptly for assistance in the management of your account.

Release of Medical Information

I authorize Oregon Eye Specialists, P.C. to release any medical information to my insurance carrier that is necessary for the processing of my medical insurance claim.

Assignment of Benefits

I authorize and request that payment of my medical insurance benefits be made on my behalf directly to Oregon Eye Specialists, P.C.

Notice of Privacy Practices Under HIPAA

Oregon Eye Specialists, PC's Notice of Privacy Practices is posted in the clinic waiting room and available in hard copy form at my request.

HMO/IPA Patients

If Oregon Eye Specialists, P.C. does not participate with my primary insurance carrier I understand that I will be responsible for the entire outstanding balance of the account that is not reimbursed by my primary and secondary insurance carrier.

I agree to pay, in full, for all medical services provided that are not authorized by the insurance carrier and that are provided on my behalf without a referral from my Primary Care Physician. I understand that it is my responsibility to provide the Primary Care Referral at the time of service.

Legal and Collection Costs

It is understood and agreed that should Oregon Eye Specialists, P.C. be required to undertake legal action to recover payments for my medical services I am responsible for all collection, legal, and court costs incurred in that effort.

I understand that in order to cover this visit, my insurance company may require a referral from my Primary Care Physician. I also understand that you may not receive authorization for a referral from my Primary Care Physician. I, therefore, understand that I will be financially responsible for any and all charges incurred at the time of the visit.

In order to effectively bill my insurance(s) Oregon Eye Specialists, PC is required to receive a newly completed patient information form, including signature, every year whether my information has changed or not.