Patient Name:_____

Date of Birth:_____

Assignment, Responsibility, Guarantee, Authorization, Ackowledgement

____(Initial) Assignment of Benefits and Release of Information
I hereby assign insurance benefits to be paid directly to Dr. Brendon Johnson for medical and vision services rendered to me. I hereby authorize the release of pertinent medical information to insurance carriers.

____ (Initial) Patient Responsibility (with medical insurance coverage)
I understand that I am financially responsible for charges not covered by my insurance benefits, workers compensation carrier or liability insurance. Office visit charge is due and payable at time of service.

____(Initial) Patient Responsibility (self pay patients)
I understand payment for all services are due at the time services are rendered.

____ (Initial) Financial Guarantee
I guarantee that in consideration of services rendered by Dr. Brendon Johnson, I will be personally responsible for any and all expenses incurred for such treatment. Also, I agree that if my account becomes past due and is placed with an agency for collection purposes, I agree to pay all collection agency fees (not to exceed 50%), reasonable attorney's fees and court costs.

_____(Initial) Acknowledgement of Receipt of Notice of Privacy Practices
I hereby acknowledge that I have been furnished with a Copy of the Notice of Privacy Practices of Dr. Brendon Johnson. The Notice provides detailed information about how the practice may use and disclose my confidential information and has reserved the right to make changes to the privacy practices that are described in the Notice.

_____(Initial) Telephone Communications
I hereby authorize the staff of Dr. Brendon Johnson to leave a message on my answering machine / voice mail.

_____(Initial) Authorization to Discuss Medical Care or Financial Information
I herby authorize the staff of Dr. Brendon Johnson to discuss appointment information, medical treatment and financial information with the following named person(s).
Please list name and relationship to patient (i.e., spouse, child, parent)

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Signature of Patient or Authorized Representative:

_____**Date:**_____

MEDICARE GUIDE FOR EYECARE

GENERAL RULES

You must pay the annual deductible toward any qualified health care before Medicare will pay for any services. After you meet your deductible, Medicare will pay 80% of the doctor's "approval fee". You will pay 20% as a co-payment, paying any non-covered fees.
If you have supplemental insurance (such as BlueCross/Blue Shield), it may cover the cost of the deductible and co-payment.

Our office will bill Medicare and accept payment directly from them if the services qualify for coverage (see exceptions below). You are responsible for paying any non-covered services at the time of your office visit.

SPECIAL EXCEPTIONS

- ***Medicare does not cover eyeglasses or contact lenses except for the first lenses following cataract surgery***
- ***Medicare does not cover the refraction part of the eye exam***
- ***Medicare may deny benefits if it feels you are receiving examinations too frequently or receiving exams by more than one doctor for the same illness.***

DR. BRENDON J. JOHNSON ***TODAY'S DATE_____***

Patient's Name_____ _____
First (Given Name) Middle Last Name you prefer to be called

Mailing Address _____City_____ State_____ Zip_____

Phone (___)_____ Cell (___)_____ E-Mail _____

Date of Birth _____ Age_____ ___ Male ___ Female Social Security # _____

IF THIS FORM IS BEING COMPLETED FOR AN ADULT PLEASE COMPLETE THE FOLLOWING INFORMATION:

Occupation _____ Employer_____ Business phone (___)_____

If married, Name of spouse_____ Date of Birth _____

Spouse's occupation_____ Employer _____Business phone (___)_____

IF FORM IS BEING COMPLETED FOR A DEPENDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

If patient is a student: Grade or Year in School_____

Father's name _____Date of Birth _____ Social Security # _____

Address (if different from patient) _____

Occupation _____ Employer_____ Business Phone (___)_____

Mother's Name_____ Date of Birth_____ Social Security #_____

Address (if different from patient) _____

Occupation_____ Employer _____ Business Phone (___)_____

Emergency Contact Person (NOT LIVING IN YOUR HOUSEHOLD)_____

Daytime Phone (___)_____ Relationship _____

Have you or any member of your immediate family been a patient of Dr. Brendon J. Johnson?

If yes, please name _____

To help our office keep more accurate records, please list any other immediate family members living at home and their ages

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How were you referred to our office? Friend or Relative (please name)_____
Newspaper _____TV_____Direct Mail_____ Yellow Pages_____ Radio _____ Sign_____ Word of Mouth _____

Please have your insurance cards, medicine list, and Driver's License ready to be copied.
NOTE: THERE IS A $25.00 FEE FOR ANY RETURNED CHECK.