

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

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.
OVER



Patient Name: _____

Date of Birth: _____

Assignment, Responsibility, Guarantee, Authorization, Acknowledgement

____ (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. I also acknowledge that my contact lens and/or glasses prescription will be available on the EHR system, and it can be faxed or e-mailed, upon my request.

____ (Initial) **No Show/Cancellation without 24-hour Notification**

I understand that there will be a \$25 reschedule fee for no show/late cancellations of appointments.

____ (Initial) **Authorization to Discuss Medical Care or Financial Information**

I hereby 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.