ALLAMAN EYE CARE & ASSOCIATES
CHRISTEN ALLAMAN, M.D.
1665 DOMINICAN WAY, SUITE 122, SANTA CRUZ, CA 95065
1667 DOMINICAN WAY, SUITE 130, SANTA CRUZ, CA 95065
PHONE: 831-476-1298; FAX: 831-476-9468
www.allamaneyecare.com

Comprehensive Eye Care Specialists

Welcome! Thank you for scheduling an appointment with Allaman Eye Care & Associates.

Your check-in time for your appointment with _____ is scheduled for:

_____ AT _____

at ☐ 1665 Dominican Way, **Suite 122** ☐ 1667 Dominican Way, **Suite 130**

Kindly have all paperwork filled out prior to your arrival to avoid delays

We look forward to caring for you. Allaman Eye Care & Associates is a full service ophthalmology office specializing in general ophthalmology, glaucoma management, diabetic eye care management, retinal examinations, dry eye treatment, state of the art vision correction and cataract surgery using the latest generation intraocular lenses for correcting presbyopia, myopia, hyperopia and astigmatism, contact lens fittings with our optometrists, and an onsite, full service optical department. Please visit our website at www.allamaneyecare.com.

Please bring your insurance cards, co-payment, completed patient registration, any glasses you are currently using (including non-prescriptive near vision glasses.) and a list of ALL medications you are currently taking. You should prepare for the possibility of having your eyes dilated at this visit by bringing dark glasses with you to this appointment.

Most appointments will take a little over one hour. For surgical evaluations, the appointment may take two to three hours.

If you are unable to attend your appointment as scheduled, please provide us with 24 hour notice and we will be happy to reschedule your appointment to a time that will be more convenient for you.

Again, thank you!

THE STAFF OF ALLAMAN EYE CARE & ASSOCIATES

ALLAMAN EYE CARE & ASSOCIATES

PATIENT REGISTRATION FORM **TODAY'S DATE: _____**

Patient Name: _____ Contact Phone: ( ) _____

EMAIL Address: _____Cell or Alternate Phone: ( ) _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Sex: M / F Date of Birth: _____ / _____ / _____ SS # _____ - _____ - _____

Occupation: _____ If retired, previous occupation(s) _____

Employer: _____ Work Phone: ( ) _____

Hobbies/Sports_____

Patient's Primary Physician_____ Name of Specialists _____

Were you referred to our practice? Y / N Referring Doctor or Refer Source_____

Person to Notify in the Event of an Emergency: _____

Relationship: _____ Phone: ( ) _____

Primary Medical Insurance: _____ Is your insurance an HMO? Y / N

Secondary Medical Insurance: _____ Co-Payment Amount: $ _____

Vision Insurance: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ / _____ / _____ Subscriber SS # _____ - _____ - _____

****PLEASE PROVIDE YOUR INSURANCE CARD TO OUR RECEPTIONIST****

Person Responsible for Billing, if other than Patient: _____

Date of Birth: _____ / _____ / _____ SS # _____ - _____ - _____

Address: _____Contact Phone: ( ) _____

Relationship to Patient: _____

**** IF YOU ARE CURRENTLY ON HOSPICE CARE, PLEASE INFORM THE FRONT DESK ****

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LIFETIME AUTHORIZATION OF INSURANCE BENEFITS AND BILLING INFORMATION FOR ALL PATIENTS

Thank you for choosing Allaman Eye Care. **Because insurance companies change their carriers, plans and benefits frequently, it is difficult for us to verify that your insurance plan is one that we are contracted with at the time of your visit. You are encouraged to verify your benefits and whether our doctors are contracted with your plan PRIOR to your visit.** We will bill your insurance as a courtesy service, but **it is your responsibility to be up to date on your insurance plan and its requirements, covered physicians, covered services, deductibles and copayment amounts.** Regardless, you will be seen by our doctors as we do not want to withhold services inappropriately. Providing services or making a copy of your insurance card **DOES NOT** confirm that you have coverage with us. If we do not contract with your insurance company, you may request a statement that outlines all necessary information required for reimbursement. _____ **Initials**

REFRACTIONS:
Refractions are performed to determine a patient's visual acuity. Most insurance companies DO NOT COVER REFRACTIVE SERVICES. Allaman Eye Care agrees to bill my refractive service to my insurance, but DOES NOT guarantee that the service will be covered. If refractive services are not covered by my plan, I agree to be responsible for the charges. _____**Initials**

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my behalf to Allaman Eye Care for any services furnished to me. I authorize Allaman Eye Care to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand that Allaman Eye Care has agreed to accept the allowed charge determined by Medicare as full charge. Medicare pays 80% of that charge and I understand that I am responsible for the balance of the charge, co-insurance and non-covered services. Co-insurance and deductibles are determined by the carrier. I understand that Medicare excludes all refractive services from their coverage. I agree to be personally and fully responsible for the refractive portion of my eye exam. Medicare (and most other insurance carriers) does not cover eyeglasses or medications, in most cases. If other health insurance coverage is indicated (secondary insurance), my signature authorizes release of the information to the insurer or agency.

HMO/PRIOR AUTHORIZATION PATIENTS: _____ **Initials**
I understand that I am ultimately responsible for authorizations for care/treatment to be provided by Allaman Eye Care. If for **ANY** reason, a service is not authorized or denied, I assume full responsibility for any and all charges, including copayments and deductibles.

Allaman Eye Care and our doctors are contracted with Dignity Health Medical Network (DHMN), formerly Physician's Medical Group (PMG) of Santa Cruz.
We are NOT providers for the Palo Alto Medical Foundation (PAMF) HMO or Kaiser Permanente HMO.

PRIVATE PAY PATIENTS: Payment for services rendered **is required at the time of service.** We offer a 10% discount as a courtesy for your payment. If at any time in the future, you become insured with medical or vision coverage, please let our staff know.

We are committed to providing quality service. With the constant changes in the healthcare arena, this can be a consuming process. Thank you in advance for your cooperation.

ALLAMAN EYE CARE & ASSOCIATES

I have read the above information. I understand that it is my responsibility to know whether Allaman Eye Care is a provider for my insurance plan. I request that payment of insurance benefits be made on my behalf to Allaman Eye Care for any services furnished to me by their physicians and suppliers and authorize any medical information necessary to ensure payment.

I understand that all charges for services rendered to me are ultimately my financial responsibility. Should I receive services and Allaman Eye Care IS NOT a contracted provider, or if the service rendered is not a covered benefit under my plan, I agree to be financially responsible and will pay in full for all such charges.

_____ _____
Patient (Responsible Party) Signature Date

A copy of this form will be provided to you at your request.

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RELEASE OF MEDICAL RECORDS AUTHORIZATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below.

I, _____ (DOB: _____/_____/____), hereby authorize the optometrist/ophthalmologist listed below to release my medical records:

From: Dr.'s Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

~~**To:**~~ **Allaman Eye Care**
Christen Allaman, MD
1665 Dominican Way, Suite 122
Santa Cruz, CA 95065
Ph: 831-476-1298
Fax: 831-476-9468

****** Please include the following information: Chart Notes, Surgical Information (including type of surgery, eye and dates, IOL model and power), refractive information, pre-op biometry, refraction, keratometry, white to white, axial length (A-Scan & IOL Master), visual field testing, OCT's, HRT's, and Photos. ******

Other: _____

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law, all recipients of healthcare information are prohibited from re-disclosing it except as specifically required or permitted by law.

Signature: _____ Date: _____

Relationship if other than patient: _____