PEDIATRIC PATIENTS (version 022023)

PATIENT'S FIRST NAME, MIDDLE INITIAL AND LAST NAME	BIRTHDATE	GENDER	SOCIAL SECURITY #

The Center of Medicare and Medicaid Services requires that we collect the patient's race, ethnicity and primary language.

RACE	ETHNICITY	LANGUAGE PREFERENCE:

FULL ADDRESS WHERE PATIENT LIVES (MUST INCLUDE STREET, CITY, STATE AND ZIP CODE)

PARENT/GUARDIAN'S FIRST AND LAST NAME	MOBILE PHONE #	BIRTHDATE	SOCIAL SECURITY #
CHECK ONE □Biological Parent □ Legal Parent □ Step/Partner Parent □Foster Parent □ Legal Guardian	EMAIL:		
PARENT/GUARDIAN'S FIRST AND LAST NAME	MOBILE PHONE #	BIRTHDATE	SOCIAL SECURITY #
CHECK ONE □ Biological Parent □ Legal Parent □ Step/Partner Parent □Foster Parent □ Legal Guardian	EMAIL:		
PARENT/GUARDIAN'S FIRST AND LAST NAME	MOBILE PHONE #	BIRTHDATE	SOCIAL SECURITY #
CHECK ONE □ Biological Parent □ Legal Parent □ Step/Partner Parent □Foster Parent □ Legal Guardian	EMAIL:		

PRIMARY PHARMACY	CROSSROADS & CITY	PHONE NUMBER
PRIMARY DOCTOR/PEDIATRICIAN'S NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER
REFERRING DOCTOR'S NAME (IF DIFFERENT)	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

If ALL of the patient's parents/guardians don't live in the same household as the patient, please provide the address/phone of the parent(s) that don't live with the patient.

_____ _____

NAME OF PARENT (child doesn't live with) **ADDRESS/CITY/STATE/ZIP**

_____ _____

NAME OF PARENT (child doesn't live with) **ADDRESS/CITY/STATE/ZIP**

Family/Friends (that aren't legal parents) ALLOWED info and/or to bring to Appointments

Please provide us with step-parents/partners, grandparents, siblings, aunts/uncles and/or friends we can talk to or allow to bring patient to see us:

PERSON'S NAME:_____ **DOB:**_____ **RELATIONSHIP:**_____ **PHONE #:**_____

PERSON'S NAME:_____ **DOB:**_____ **RELATIONSHIP:**_____ **PHONE #:**_____

CEC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to CEC for reimbursement for services rendered, and (2) any health care provider for continued patient care. CEC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statue or regulation. A copy of this authorization may be used in place of the original. I authorize that my protected health information (also known as PHI) may be used or disclosed with the above-mentioned people. I understand that I have the right to be aware of all PHI that will be disclosed to these people. I understand that Children's Eye Care will not condition any aspect of my treatment or payment I understand that I am under no obligation to sign this Authorization. I understand that this Authorization may be revoked in writing at any time by my signing the revocation section below and returning it to Children's Eye Care unless: they have previously acted in reliance on this Authorization. By my signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to Children's Eye Care to use or disclose PHI in accordance to the terms of the Authorization. **Financial Agreement:** I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to CEC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to CEC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. Also, I agree to reimburse CEC the fees of any collection agency , which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

CEC does NOT participate/bill VISION/wellness plans; your medical plan will be billed. If the visit is applied to deductible/co-insurance, these are the common ranges of what carriers choose as their allowed amount: Exam (patient not seen within 3 years $160-190, patient seen within 3 years = $80-160), determination of refraction (92015 = $25-30) and a sensorimotor (92060 = $60-90).

PATIENT/PARENT/GUARDIAN'S PRESENTING WITH PATIENT TODAY:_____ DATE:_____